**ADULTS WITH SEVERE MENTAL ILLNESS**

**Criterion 1: Comprehensive Community Based Mental Health Services System**

***The plan provides for the establishment of a recovery oriented, comprehensive, community-based system of mental health care for adults who have a severe mental illness, including case management, treatment, rehabilitation, employment, housing, educational, medical, dental, and other support services, which enables individuals to function in the community and reduces the rate of hospitalization.***

***GOAL: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.***

**Description of the Organization of the System of Care**

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) administers a recovery oriented, comprehensive, community-based system of mental health care for adults with severe mental illness through contracts with Kentucky's Regional MH/MR Boards. KDMHMRS works with Kentucky Medicaid so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible consumers.

To encourage the development by Regional MH/MR Boards of a full array of clinical, rehabilitation, and support services for adults with severe mental illness within their regions, KDMHMRS uses two strategies within its budgeting process. These strategies are:

- Priority Populations
- Community Support Services

Since 1985, KDMHMRS has required Regional MH/MR Boards to prioritize certain populations, including adults with severe mental illnesses, in their budgeting processes. Despite budget deficits and competing priorities among the various program areas and service initiatives, funding levels for adults with severe mental illness have been maintained. As new funds have become available, further development of an array of community-based services has occurred. In addition, sub-populations who are historically under or inappropriately served have been prioritized including adults with severe mental illnesses who:

- Have co-occurring disorders
- Are homeless
- Are deaf or hard of hearing
- Are elderly
- Are of African-American descent

**The Ideal Array of Community Support Services**

To effectively meet the needs of adults with severe mental illness, KDMHMRS has worked with consumers and other stakeholders to identify and fund an ideal array of services that support adults with severe mental illness in the community. These are organized along six major components:

- **Consumer and Family support**
- **Outpatient Mental Health Services**
  - Emergency Services
  - Continuity of Care Initiatives
  - Mental Health Treatment
- **Specialized Services for Adults with Severe and Persistent Mental Illness**
  - Case Management
  - Rehabilitation
- **Housing Services**
- **Systems Interface**

Criminal Justice
Physical Health

- **Special Populations Services**
  Persons who are aging
  Persons who are deaf and hard of hearing
  Persons with Brain Injuries

The narrative provided for Criterion One describes these key components of the comprehensive Community Support Services array, and presents State Perspective objectives for the coming year for their continued development. A list of Community Support Services in the ideal array and a representation of their current availability by region are shown in the following table:

**Regional Availability of Community Support Services SFY 04**

| | ***Region*** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community Support Component** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9/ 10** | **11** | **12** | **13** | **14** | **15** |
| Consumer and Family Support | | | | | | | | | | | | | | |
| Training and Advocacy | | X | X | X | X | X | X | | | X | X | X | | |
| Consumer Support Group | | X | X | X | | X | X | | | X | X | X | X | X |
| Local NAMI of Kentucky | X | X | X | X | X | X | X | | X | | | | X | X |
| Consumer Conferences | X | | | | | X | | | | | X | X | | X |
| Peer Advocates/Crisis Response | | | | X | | X | X | | | X | | | | |
| Outpatient Mental Health Services | | | | | | | | | | | | | | |
| Emergency-Help Line | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Walk-In Crisis Services (8-5,M-F) | X | X | X | X | X | | X | X | X | X | X | X | X | X |
| Mobile Crisis Services | | | | | | | | | X | | X | | | X |
| Residential Crisis Stabilization | X | | X | X | X | X | | X | X | X | X | X | X | X |
| Medication Management | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Community Medications Support | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Outpatient Therapy | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Intensive Outpatient | | X | | | | | | | | | | | | |
| Continuity of Care | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Integrated MH and SA Services | | | | | X | X | | | | | X | | | X |
| Specialized Services | | | | | | | | | | | | | | |
| Case Management | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Wrap around Services | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Therapeutic Rehabilitation | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Supported Employment | | | X | X | | X | | | X | X | | X | X | X |
| Educational Services | | | | | X | X | | X | X | X | X | | | X |
| Other Community Support | X | X | X | X | X | X | X | | X | X | X | X | X | X |
| Specialized Int. Case Management | | X | | X | | | | | | | X | | | |
| Assertive Community Treatment | X | | | | | | | | | | X | | | |
| Housing Options | | | | | | | | | | | | | | |
| Homeless Outreach | X | X | | X | | X | | X | | | X | | | X |
| Payee Services | | X | X | | X | X | X | X | X | | | | | X |
| Supported Housing | | X | X | X | X | X | | | | | X | | | X |
| Residential Support | | X | X | X | X | X | X | | X | | X | X | | X |
| Housing Development | | X | | X | | X | X | | X | | | | | X |
| Systems Interface | | | | | | | | | | | | | | |
| Criminal Justice | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Physical Health | | | | | | X | | | | | | | | |
| Special Populations | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aging | | | | | | | | | | | | | | |
| Deaf/Hard of Hearing | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Brain Injury | | | | | | | | | | | | | | |

**Component 1: Consumer and Family Support**

**REGIONAL PERSPECTIVE**
The regional community mental health centers have reported in their annual plan and budget that:

- Eleven regions have Training and Advocacy initiatives
- Ten regions have consumer support groups
- Six regions have consumer run drop in centers
- Eight regions have local NAMI chapters with two more under development in SFY 05
- Ten regions have a consumer conference
- Five regions have peer advocacy
- One region has crisis response
- One region has peer volunteers
- Seven have designated consumer staff
- Thirteen have consumer involvement on board of directors/planning committees

In addition, many CMHCs reported that supporting consumer involvement in consumer conferences, the Leadership Academy, and other statewide initiatives by providing transportation has heightened consumer access to knowledge and involvement in planning a consumer and family driven mental health care system.

**Regional Plans For Development**
Regional Plans For Development for this component were submitted by the following regions:

Region 7 - Increase opportunities for consumers and families to have input regarding program planning and evaluation over the next fiscal year.

**STATE PERSPECTIVE**
Since the mid-1980s, KDMHMRS has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding.

The Department provides funds for a variety of statewide and local consumer and family support initiatives. Each has goals related to advocacy, research, discrimination, wellness and recovery programs, peer support, education and training, and operating support.

The **Mental Health Consumer Advocacy Steering Committee** is the current iteration of a consumer education and involvement function that the Department has had for about fifteen years. The Committee provides a way for the Department to fulfill its Block Grant obligation to involve consumers in planning. It also provides a direct communication link to consumers and family members who are vocal advocates in other arenas of government. Finally, it brings together grass roots organizations with similar missions to reduce duplication of effort.

Through its membership, the following services are provided:

- Provide family-to-family and consumer-to-consumer illness education programs and support groups;
- Provide peer advocates to assist the Department in placing adults subject to the Olmstead decision out of psychiatric hospitals;
- Develop legislation for recovery initiatives;

- Prepare persons recovering from mental illness to participate on local and regional planning boards and in other service system activities. These individuals will meet for continuing training and development as a subcommittee, the "Mental Health Consumer Advocacy Committee."
- Develop a brochure about grievance procedures; and
- Improve access to "Ticket to Work" and other employment initiatives.

The **Mental Health Commonground Training and Resource Center (CTC)**, a joint project of the Consumer Advocacy Committee, the Kentucky Consumer Advocate Network (KY CAN), and NAMI Kentucky, is a consumer run technical assistance center designed for statewide training, information dissemination and technical assistance. Activities provided by the CTC include the coordination of three leadership academies, provision of hardware and software support to KYCAN, NAMI and individual consumers and family members, technical assistance in planning, services provision, and internet technology. Activities proposed for SFY 05 include:
- Explore the use of technology to expand access to the Mental Health Consumer Advocacy Committee;
- Initiate a program that uses multimedia to address issues of discrimination against consumers;
- Advocate for family and consumer technical participation; and
- Explore and use technology to provide cost effective service and consensus building.

KDMHMRS and the Regional Boards use a number of strategies to support consumer and family involvement. While funds are limited, a significant amount of block grant funding supports the operations of the statewide consumer organization, Kentucky Consumer Advocacy Network, as well as The Recovery Network of Northern Kentucky. The state wide family organization, NAMI Kentucky also receives block grant funds. Additional strategies include:
- Encouraging increased collaboration between Regional Boards and KY CAN and NAMI Kentucky in sponsoring "Bridges" and Family-to-Family" support groups;
- Providing reimbursement for consumer and family members to attend state and regional meetings, conferences, and other gatherings;
- Requiring that regional planning councils review plans submitted to KDMHMRS regarding block grant funds;
- Changing CMHC contract language to encourage a consistent grievance process statewide;
- Sponsoring a Consumer Leadership Training Academy and a Train-the-Trainer Academy; and
- Continuing to support the KY CAN Consultative Peer Review program.

While KDMHMRS and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain. These include:
- No dedicated funding for consumer run services;
- Few programs incorporate recovery principles;
- Perception of risk in hiring consumers;
- Limited number of consumer run services that can serve as "mentor' programs; and
- Persistent transportation barriers to attending meetings and other events.

**Component 2: Outpatient Mental Health Services**

**This component is comprised of three major elements:**
- **Emergency Services**
- **Continuity of Care**
- **Mental Health treatment**

***Emergency Services***
**REGIONAL PERSPECTIVE**

- All fourteen regions have a 24 hour Crisis and Information line
- All fourteen regions have qualified mental health professionals on call for emergency evaluations for psychiatric hospitalization 24 hours a day, 7 days a week
- All regions respond within 3 hours to a request for involuntary hospitalization evaluation
- Crisis Stabilization Units are available in 12 regions
- Crisis Stabilization Case Management Services are available to 2 regions
- Training is provided to law enforcement related to accessing emergency care in every region.

**Regional Plans for Development**

The following regions chose this component as area of focused development for SFY 05:

- Region 1: Annual Goal: Increase community awareness of the Adult Crisis Stabilization Unit
- Region 4: Annual Goal: Increase average daily census to six in the ACSU
- Region 9/10 Annual Goal: Increase training for Crisis Service staff to 40 hours

**Regional Emergency Services Plans for Development**

Regional Boards were required to submit a plan for development for the improvement of their emergency services for SFY 05. A summary of the goal for each region follows:

| Region | Plan for Development |
|---|---|
| 1 | Obtain contracts for Hospital Emergency Consultations for Adults |
| 2 | Assessments for Emergency Hospitalization will be done within three hours of request for service |
| 3 | Assessments for Emergency Hospitalization will be done within three hours of request for service |
| 4 | Increase ACSU Average Daily Census to six |
| 5 | Creation of data base regarding consumers of Emergency Services |
| 6 | Provide Evidenced Based Suicide Risk Assessments |
| 7 | Increase CSU utilization by 25% |
| 8 | Implement an ACT project region wide |
| 10 | |
| 11 | Reduce CSU readmissions by 25% |
| 12 | Improve quality, timeliness and effectiveness of Emergency Services |
| 13 | Reduce involuntary hospitalization evaluations by ten |
| 14 | |
| 15 | Improve clinical response to consumer who present as suicidal |

**STATE PERSPECTIVE**

Beginning in 1995, KDMHMRS has made a concerted effort to develop a statewide network of Crisis Stabilization Programs. These programs, which primarily serve individuals with serious mental illness, can be home-based interventions or residential units and are a major factor in Kentucky's reduction of inpatient utilization. In SFY 04, funding was allocated to complete the statewide network by having a Crisis Stabilization Program in each Regional MH/MR Board service area.

The KDMHMRS Crisis Stabilization Coordinator supports the ongoing development and enhancement of the network by facilitating periodic meetings of crisis stabilization program director and training events.

KDMHMRS funds a full range of crisis services that include:

- 24 hour emergency hotlines;
- Warm lines;
- Walk-in Crisis Services;
- Mobile Crisis Services;
- Suicide Hotlines;
- Residential Crisis Stabilization Units;
- Overnight Crisis Beds;

- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations;

A major initiative will be implemented in SFY 05 with the Passage of HB 157 that mandates the establishment of a statewide behavioral health telephonic triage system to be utilized by local jails. This system will be used to screen jail inmates at booking for mental health, suicide risk, mental retardation and acquired brain injury and to make recommendations about housing, classification and treatment needs. This is a unique program as no other state in the nation operates a system of screening and assessment through a partnership between community mental health and local jails.

***Continuity of Care/Reduction in Inpatient Psychiatric Care***

**REGIONAL PERSPECTIVE**

KDMHMRS allocated new CMHS Block grant funds during SFY 2001 to develop two outreach specialist positions to evaluate the effectiveness of Strategies to improve aftercare performance by Regional Boards. The Outreach Specialists focus on efforts to engage persons with severe mental illness who have either "served out" from a correctional facility or been recently discharged from a state psychiatric facility. Additional areas of focus for Regional MH/MR Boards include:

- Insuring outreach and seamless services to individuals in transition;
- Insuring that relevant services are available and accessible;
- Maintaining linkages with discharge planners, family members and others; and
- Monitoring relevant performance indicators (appointment follow-up, hospital readmission).

**STATE PERSPECTIVE**

The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is key to insuring a successful transition from the hospital to the community.

Providing appropriate aftercare following a state hospital stay is critical to reducing readmission rates. The Department requires a Regional MH/MR Board to provide an outpatient appointment within two weeks of a discharge. KDMHMRS also requires the provision of case management services to adults with severe mental illness who are discharged from a state psychiatric facility, are determined by hospital staff to be in need of case management service, and agree to receive this service.

The fourteen Regional MH/MR Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient referrals. Some Regional MH/MR Boards function as single portal of entry for some of the hospitals. Due to the uniqueness of the providers and each individual they serve, a need to re-institute regular continuity of care meetings between the respective hospital and local Regional MH/MR Boards was identified in SFY 02 and KDMHMRS staff initiated the reconvening of these meetings. The agenda for each meeting includes the following topics:

- Aftercare performance
- Community Medications Support Program
- Olmstead planning
- Continuity of care systems issues
- Consumer issues
- KDMHMRS Performance Indicators
- Other issues requested by participants

During SFY 04, KDMHMRS worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional MHMR Boards to develop a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need to develop these MOAs was identified to strengthen the relationships between the hospitals and the

Boards. The MOAs include the contractual responsibilities each entity has to the KDMHMRS, but also defines and clarifies roles and responsibilities the hospital and mental health center have to assure quality continuity of care to patients that they both serve.

KDMHMRS strategies to reduce unnecessary psychiatric inpatient utilization include the development of residential crisis stabilization programs, responsive emergency services, assurance of continuity of care and the continued development of other community support services as effective alternatives for adults with severe mental illness who are in crisis.

KDMHMRS has responsibility for the monitoring of the **Olmstead Initiative** in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of the representatives from the hospital, the Regional MHMR Board, KDMHMRS staff, and other appropriate stakeholders meet on a frequent basis to review transition plans that assure a smooth and timely discharge to the community for identified patients. Funds were appropriated during the 2002 legislative session to pay for individualized and specialized wraparound services to assure the community tenure for each of these individuals.

Kentucky has reduced its state hospital beds by more than 90 percent from the 7,689 beds available in 1955. From SFY 95 through SFY 98 the average daily census decreased by 20% at the four non-forensic state-supported psychiatric hospitals.

While lengths of stay in state hospitals continue to decrease, continuity of care issues remain. A number of challenges are presented to KDMHMRS and the Regional Boards. These include:

- Private psychiatric beds have been closing or are being converted to acute care beds which generate more revenue;
- The loss of private psychiatric beds in local private hospitals has placed a strain on state operated psychiatric hospital by increasing admissions;
- While crisis stabilization programs have existed in all fourteen regions by the end of SFY 04, confidence in their appropriateness as alternatives to hospitalization remains low among most psychiatrists; Supervised residential options are sparse throughout Kentucky, thwarting efforts to discharge individuals with complex service needs;
- The unavailability of adequate funding for community-based services as alternatives to hospitalization remains a barrier to good continuity of care; and
- Reduction in funding to the state operated facilities impedes continuity of care.

The following two charts display average daily census and average length of stay within state hospital settings.

**Funded Entities**

**Regional MH/MR Boards**

Region 1
***Four Rivers MH/MR Board, Inc.***
1526 Lone Oak Road
Paducah, Kentucky 42003

Region 2
***Pennyroyal Regional MH/MR Board, Inc.***
PO Box 614
Hopkinsville, Kentucky 42241-0614

Region 3
***River Valley Behavioral Health***
PO Box 1637
Owensboro, Kentucky 42302-1637

Region 4
***LifeSkills, Inc.***
PO Box 6499
Bowling Green, Kentucky 42101-6498

Region 5
***Communicare, Inc.***
1311 North Dixie Avenue
Elizabethtown, Kentucky 42701

Region 6
***Seven Counties Services, Inc.***
101 W. Muhammad Ali Blvd.
Louisville, Kentucky 40201

Region 7
***NorthKey Community Care***
PO Box 2680
Covington, Kentucky 41012

Region 8
***Comprehend, Inc.***
611 Forest Avenue
Maysville, Kentucky 41056

Region 9/10
***Pathways, Inc.***
PO Box 790
Ashland, Kentucky 41100

Region 11
***Mountain Comp. Care Center***
150 South Front Avenue
Prestonsbug, Kentucky 41653

Region 12
***Kentucky River Community Care***
PO Box 794
Jackson, Kentucky 41339-0794

Region 13
***Cumberland River Comp. Care Center***
PO Box 568
Corbin, Kentucky 40702

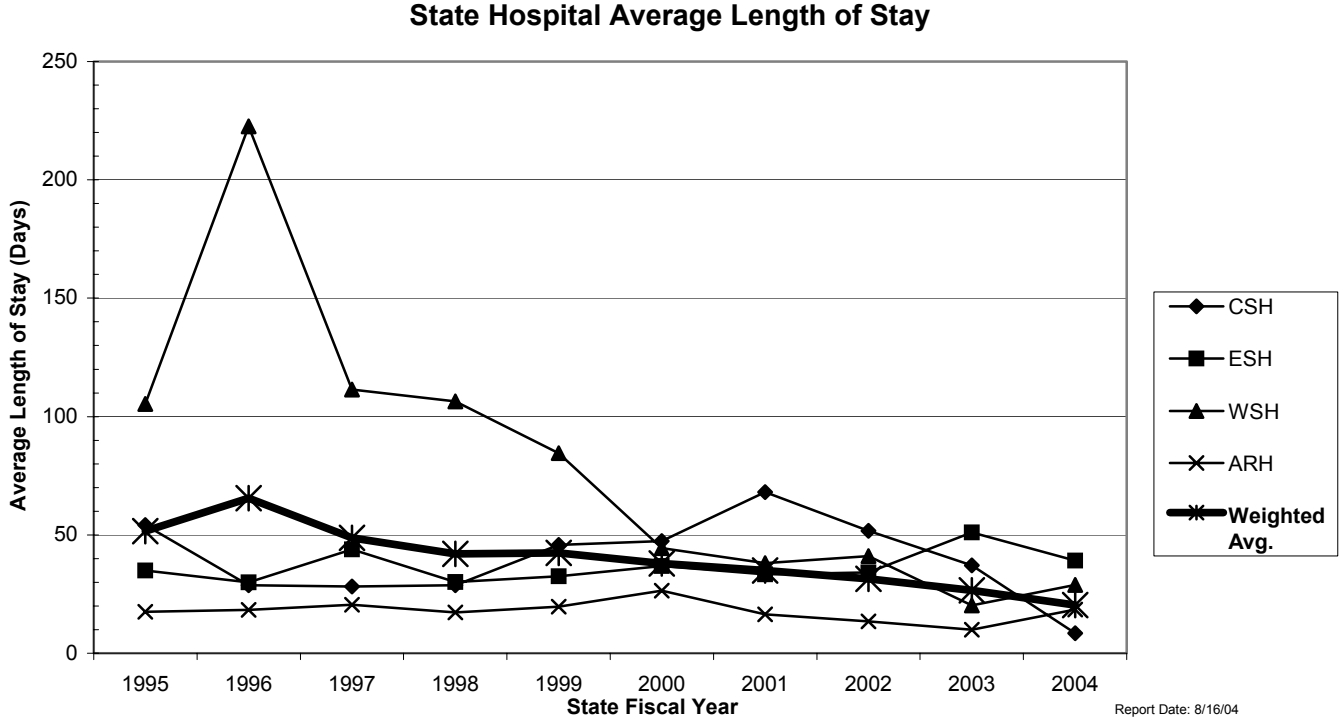
Region 14
***The ADANTA Group***
259 Parkers Mill Road
Somerset, Kentucky 42501

Region 15
***Bluegrass Regional MH/MR Board, Inc.***
PO Box 11428
Lexington, Kentucky 40574

**Other Funded Entities**

***Eastern Kentucky University***
100 Stratton Building
Richmond, Kentucky 40675

***Kentucky Housing Corporation***
1310 Louisville Road
Frankfort, Kentucky 40601




Report Date: 8/16/04

***Mental Health Treatment***

**REGIONAL PERSPECTIVE**

Budget constraints have forced some regions to scale back availability of mental health treatment services in less populous, rural counties. Additional challenges include:

- While all regions report having a system for following up with missed appointments, most recognize the need to provide assertive outreach so fewer appointments are missed.
- The majority of regions have a method to assure medication continuity within the agency when level of care changes.
- A shortage of professional staff, especially psychiatrists, has caused waiting periods for appointments to continue to grow.
- Continuity of care with inpatient settings and other community providers continues to be a major challenge in providing quality, holistic care
- Screening for substance abuse disorders/co-occurring disorders occurs in every region with varying levels of comprehensiveness of the assessment process.
- The majority of regions provide opportunities for training regarding substance abuse disorders to their mental health staff.

**Regional Plans For Development**

This component was chosen as area of focused development for SFY 05 by the following regions:

| Region | Plan for Development |
|---|---|
| 2 | Will ensure that anyone in need of psychiatric services is scheduled within 30 days. |
| 8 | Provide quarterly training to mental health staff on substance abuse disorders |

**STATE PERSPECTIVE**

The Department funds Regional MH/MR Boards to provide an array of mental health treatment services. These services include medication management, individual therapy, group therapy, intensive outpatient services and integrated services for persons with co-occurring mental health and substance abuse disorders to non-Medicaid individuals with mental illness.

In addition to funding this array of mental health treatment services, KDMHMRS funds the **Community Medication Support Program (CMSP).** The Community Medication Support Program is a drug replacement program that provides low cost medications to the population who are living at a standard below poverty level and who do not otherwise qualify for federal or state assistance. The previous success of this program is the result of a unique collaborative effort by the state operated/contracted psychiatric hospitals, the Regional MH/MR Boards, KDMHMRS, and local pharmacies. The goal of the program is to assist adults in the community with a severe mental illness who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies, then the medications are replaced to the pharmacies by our state operated/contracted hospitals. The program is available in all regions. Eligibility for the CMSP is based on age (18+), income (federal HHS poverty guidelines and no third party payer sources), and KDMHMRS criteria of severe mental illness (diagnosis, disability and duration).

Current challenges faced include:

- Adequate availability of mental health professionals
- Assertive Outreach is an identified priority across the Commonwealth.
- Evidence-based practice in clinical care is a KDMHMRS priority and are encouraged and supported at all levels. KDMHMRS is working with individual Boards to introduce the Level of Care Utilization System (LOCUS) and to introduce treatment guidelines for specific mental health conditions.
- HB 843, which established the Kentucky Commission on Services and Supports for Persons with Mental Illness, Alcohol and other Drug Abuse Disorders and Dual Diagnosis, issued their final report in June 2001. Included in this report were two significant recommendations related to co-occurring disorders. The Commission emphasized a need for increased

initiatives related to cross-systems training for both, mental health and substance abuse professionals, as well as the development of more integrated service delivery systems, both at the state and Local Level.

**Performance Indicators and Action Plans for this component are at the end of this Criterion**

**Component 3: Specialized Services for Persons with Severe and Persistent Mental Illnesses**

**This component is comprised of Case Management Services and Rehabilitation Services**

***Case Management Services***
Case management is an essential Community Support Service because it coordinates an individual's service array, making maximum use of available formal and informal supports. Case management has been available through Regional MH/MR Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Priority is given to adults with severe mental illness who have the greatest difficulties accessing resources and those with more intense service needs. Kentucky embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp) blended with the psychiatric rehabilitation model endorsed by Boston University (Dr. William A. Anthony).

**REGIONAL PERSPECTIVE**
A review of the information from the SFY 05 regional plan applications reveals that case management services are available in all 120 of Kentucky's counties. Currently, over 6700 individuals are served by 200 case managers. As anticipated, fewer individuals were served by case management in SFY 04 due to the freezing of Kentucky Medicaid rates as well as the need to serve individuals with more severe needs (e.g. individuals who meet the Olmstead profile). Case management in Kentucky provides support to individuals in a variety of ways including:

- Two regions have an Assertive Community Treatment Team;
- One region received a planning grant to develop an Assertive Community Treatment Team.
- Three regions have mobile outreach teams;
- Two regions provide specialized intensive case management for forensic clients and;
- Four regions provide continuity of care case management for special populations.

During SFY 05, efforts will continue to involve stakeholders in identifying key components essential to an Assertive Community Treatment (ACT) model particular to Kentucky, as well as to explore potential funding mechanisms. Additionally, DMH staff will continue to provide technical assistance to existing, modified ACT programs operating in the state. Efforts will also continue to develop partnerships and collaborate with state colleges and universities in developing and incorporating case management training and curriculum into routine class work for students training to provide mental health services.

**Regional Plans For Development**
Regional MH/MR Boards submitted the following plans for development in case management serving adults with severe mental illness:

| Region | Plan for Development |
|---|---|
| **2** | Enhance the ability of case management staff to meet the needs of clients who are dually diagnosed MH/SA by providing in-service training to all SMI case managers in identification, evaluation, and treatment of clients with a co-occurring disorder, MH/SA. |
| **5** | Increase case management outreach to the SMI aging population by participating in monthly |

| | |
|---|---|
| | interagency meetings. |
| **11** | Mountain Comprehensive Care Center will improve continuity of care through case management by recruiting and training two additional case managers to focus on continuity of care issues and by increasing the incidence of off-site community contacts to 75%. |
| **12** | Continue to expand and improve services to persons in KRCC who have SMI and who are homeless by continuing to support the Appalachian Assertive Services Partnership (ACT Team) and by seeking expansion funds from SAMHSA and KDMHMRS to add two additional Assertive Community Treatment Teams to provide outreach case management services to the rural homeless population. |

**STATE PERSPECTIVE**

KDMHMRS supports case management through the Regional MH/MR Boards in a variety of ways:

- The Division of Mental Health, Adult Services Branch, designates a statewide coordinator of case management services;
- KDMHMRS requires and provides certification training for all case managers within six months of employment;
- KDMHMRS, in collaboration with the Kentucky Department of Education Division of Exceptional Children Services, the State Interagency Council for Services to Children with an Emotional Disability, the Kentucky Center for School Safety, the Office of Family Resource and Youth Services Centers, and the Department of Juvenile Justice conducts a continuing education conference that is specific to developing best practices in case management for a broad range of populations and needs;
- KDMHMRS funds demonstration projects for the provision of case management services of a more intensive design to persons with severe mental illness who have a history of violent or volatile behavior;
- Evidence-based practices such as Assertive Community Treatment are in varying stages of implementation as pilot projects in a few regions in the state and are being studied for possible expansion and implementation in other regions; and
- KDMHMRS has established a case management partnership including representatives from mental health, mental retardation, substance abuse, brain injury services, and the Department for Medicaid Services. This partnership, called the case management work group, has developed a common definition, principles and practice guidelines. This group is exploring commonalties for training and service quality improvement.

***Rehabilitation Services***

**REGIONAL PERSPECTIVE**

A review of the information from the SFY 05 regional plan applications reveals that access to rehabilitation services are available in all 120 of Kentucky's counties.

- All fourteen regions provide access to Therapeutic Rehabilitation Program services with 85 programs available throughout the state;
- Six regions provide access to long term supports through supported employment services for adults with severe mental illness;
- Four regions have specifically adopted the psychiatric rehabilitation model to direct their rehabilitation services; and
- All fourteen regions provide access to educational support through community support program services.

Although adult rehabilitation services are available to individuals in all 120 counties in the state, access to services is inconsistent and often inadequate to meet the need. The federal estimate of 2.6% of the adult population as having a severe and persistent mental illness identifies about 89,000 adults in Kentucky as meeting this criterion. In SFY 03, the statewide average for adults served by the regional MH/MR Boards was 36% serving 29,297 adults with SMI. Yet only 4,130 persons received a TRP service and 1,646 people received supported employment. The majority of adults with severe mental illness in the state do not participate in rehabilitation services offered

through the Regional MH/MR Boards. National estimates report that approximately 43% of adults with a psychiatric disability are employed full or part time yet statistics for Kentucky indicate that only 13% of people with psychiatric disabilities are employed.

The delivery of quality, timely rehabilitation services is challenged by a number of factors including:

- The current billing system that limits therapeutic rehabilitation as a site based service limiting community skills taught in the natural community;
- Kentucky Medicaid rates for therapeutic rehabilitation are quite low and significantly below the reimbursement rate for outpatient treatment services;
- Therapeutic Rehabilitation Program services are inconsistent and have not adopted a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a severe mental illness; and
- Supported education is not reimbursed by Medicaid and is actually interpreted by some centers as being discouraged due to the possible interpretation of duplicity of services.

**Regional Plans For Development**
Regional MH/MR Boards submitted the following plans for development for rehabilitation services serving adults with severe mental illness:

| Region | Plan for Development |
|---|---|
| **2** | Increase the opportunity for SMI clients to obtain either sheltered or supported employment. |
| **7** | Increase opportunities for adult consumers and families to have input regarding program planning and evaluation over the next fiscal year. Increase the number of staff trained in Emerging Best Practices in Mental Health Recovery which enhances consumer and staff partnership in the treatment process. |

**STATE PERSPECTIVE**
KDMHMRS incorporates the philosophy of "psycho-social rehabilitation" (outcomes improve when skills are taught in a social setting) and **"**recovery**"** (outcomes and satisfaction improve when consumers develop new meaning and purpose in life and grow beyond the catastrophic effects of mental illness) to assist the development of Community Support Services. As psychiatric rehabilitation technology has evolved, KDMHMRS has promoted rehabilitation and recovery models through training, education, technical assistance, and targeted funding opportunities.

KDMHMRS promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two decades. This model also addresses the four major components of Community Support Services identified by KDMHMRS with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

Currently KDMHMRS, Kentucky Medicaid, the Regional MH/MR Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted various models but, without system support, have had difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

KDMHMRS supports the provision of three key rehabilitative services at the regional level: therapeutic rehabilitation, supported employment, and supported education. While they each rely on psychiatric rehabilitation technology, they are supported in very different ways.

KDMHMRS supports rehabilitation services through the Regional MH/MR Boards in a variety of ways:

- The Division of Mental Health, Adult Services Branch, designates a statewide community support program coordinator;
- KDMHMRS offers technical assistance and training for Community Support Program Directors who coordinate services for the state's eighty-five (85) **therapeutic rehabilitation programs** (TRP). **Therapeutic rehabilitation programs** are goal directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming.
- KDMHMRS has an interagency agreement with the Department for Vocational Rehabilitation that uses CMHS Block Grant funds to leverage **supported employment** services for adults with severe mental illness. In SFY 03, 1646 individuals in the state were served with supported employment.
- KDMHMRS worked collaboratively in SFY 03 and SFY 04 with the Kentucky Business Leadership Network to increase employment opportunities for adults with severe mental illness through planning and participating in business forums that promote community awareness and education and the implementation of a job placement website for adults with disabilities.
- Efforts during SFY 04 focused on bringing stakeholders together to implement provisions of the Ticket to Work and Work Incentives Improvement Act of 1999, legislation that has major implications for individuals with psychiatric disabilities, as well as all persons with disabilities. In addition, a concentrated focus was placed on the need for advocacy and for potential new supported employment funding for long-term supports.
- Efforts during SFY 04 also focused on working with the HB 843 Supported Employment Workgroup to advocate and plan for additional long-term supports, new employment funding, and expansion of supported employment options.
- Improving access to **educational services** through sites that provide Community Support Services was a new priority for SFY 04. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills necessary to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with a serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services has been a priority for Community Support Program Directors in community mental health settings.

**Component 4: Housing Options**

**REGIONAL PERSPECTIVE**

During SFY 05, the Department, Kentucky Housing Corporation (KHC) and the Kentucky Association of Regional Programs will continue collaborating on the development of a Statewide Housing Project involving low-income housing tax credits. This project involves the construction of twelve new units of scattered site affordable rental housing in a number of rural counties. Regional MH/MR Boards will serve as local project sponsors and be responsible for site selection, construction, tenant selection, property management and service provision.

Regional MH/MR Boards use a variety of strategies to develop housing options for individuals with severe mental illnesses. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs or through collaborative arrangements with local public housing agencies. A review of the information from the SFY 05 regional plan applications reveals that:

- Eleven Regional Boards are actively involved in housing development;
- Eleven regions operate housing projects that provide residential support;
- Seven regions have organized formal supported housing programs;
- Eight regions report having developed a regional housing plan; and
- Eleven regions provide specialized housing training to agency staff.

**Regional Plans For Development**
It is anticipated that in SFY 05, Regional MH/MR Boards will continue to develop a modest amount of new housing units. Regional MH/MR Boards submitted the following plans in this area:

| Region | Plan for Development |
|---|---|
| 2 | Pennyroyal Regional MH/MR Board plans to construct and open four residential units, to increase the availability of affordable, acceptable, and safe housing for persons with SMI. |
| 12 | Kentucky River Community Care will continue to be a leader in developing supported housing for Kentuckians with severe mental illness by developing at least six more units of supported housing in Lee County during the year. |

**STATE PERSPECTIVE**
KDMHMRS began funding a full-time Statewide Housing Coordinator in 1993 to work with consumers, Regional MH/MR Boards, and the Kentucky Housing Corporation (KHC) to develop housing options. The Housing Coordinator supports local efforts through:
- On-site technical assistance with local housing developers;
- Quarterly housing meetings;
- Special training events; and
- Collaboration with the Kentucky Housing Corporation, the Housing and Homeless Coalition in Kentucky, the State Housing Policy Advisory Committee, the Council on Homeless Policy and other key state housing organizations.

Additionally, KDMHMRS collaborates with KHC in two key initiatives:
- The Supportive Housing Specialist position, which is jointly funded by the KHC and KDMHMRS, works to further integrate the housing needs of persons with mental illness into the state housing finance agency's programs. Technical assistance and consultation in developing housing projects is provided to local nonprofits by the Specialist.
- KDMHMRS provides $400,000 in annual funding to KHC to create a "set-aside" account within KHC's Affordable Housing Trust Fund (AHTF). The AHTF was established in 1996 to spur development of new housing projects for individuals with mental health, mental retardation or developmental disabilities, or substance abuse problems. Through December 2003, approximately 44 projects housing the Department's priority populations have been developed. These projects have provided 346 units in a mix of permanent and transitional housing settings.

Many Regional Boards have developed housing options for their clients, but this can never be the central mission of the organization. More partnerships are needed with local public housing agencies, non-profit and for profit housing developers, and other housing and service agencies. The Regional Planning Councils for the HB 843 Commission, non-profit developers and housing advocates have identified the following needs and barriers to housing.
- Consumers need increased availability of affordable housing options throughout the state.
- There needs to be more direct state funding and federal matching monies for housing options that include independent living, transitional housing, halfway houses, group homes, assisted living, supervised apartments and sober housing for individuals in recovery.
- Collaboration should take place with the Kentucky Housing Corporation and other agencies to finance housing developments for consumers.
- There should be increased state funding for housing supports and increased housing options for persons at risk of institutionalization.

- There is insufficient funding for housing related support services.
- In the rural areas, there is a lack of appropriate housing and nonprofit developers. HUD Fair Market Rent in these areas is too low to make subsidized housing financially viable.
- Many persons with a mental illness have experienced legal, financial and eviction problems which exclude them from housing programs.
- Stigma of mental illness remains a problem, excluding persons from some homeless shelters and housing services.
- Waiting lists for Section 8 vouchers are many months and sometimes years long in most parts of Kentucky.

**Performance Indicators and Action Plans may be found at the end of this Criterion**

**Component 5: Systems Interface**

**This component focuses on the interface of the mental health system with both the physical health system and the criminal justice system.**

***Physical Health System***
**REGIONAL PERSPECTIVE**
Regional MH/MR Boards are required to assess the physical health of each consumer they serve. Clinicians and case managers work closely with parents, community primary care physicians, local health departments, other health care providers, and schools to address the overall health needs of adults. Physical health services are available through Medicaid or local "free" clinics that provide indigent health care.

Regional Boards report the following activities in their plans for SFY 05:
- All fourteen regions state that physical health needs are addressed when individual service plans are developed;
- Most regions track clients who receive a physical or dental exam directly or by CMHC referral and follow-up;
- Most regions have formal or informal initiatives with physical health providers; and
- Most regions report having a process for tracking referrals to Public Health Departments or primary care providers.

**STATE PERSPECTIVE**
The interface of physical health and mental health is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in the physical healthcare arena. Continuity of care across these systems is critical if individuals are going to recover and succeed in establishing chosen roles in the community.

To help focus on improving access to dental and physical health services, a representative of the Department for Public Health was recommended as a member of the Kentucky Mental Health Services Planning Council. That representative has been attending planning council meetings since SFY 03 and contributing valuable suggestions for collaboration between the physical health and mental health system.

***Criminal Justice System***
**REGIONAL PERSPECTIVE**
Regional Boards provide training to a number of entities in the criminal justice system in order to assure persons with severe mental illness are diverted into treatment rather than arrested and booked into jail whenever possible. In Jefferson County the Crisis Intervention Team has been in place for over 2 years and has successfully diverted thousands of individuals into care.
Relationships between Regional MH/MR Boards has been enhanced through the delivery of the mental health and suicide prevention training that the Boards have been providing to local jails. Funding was also included to provide consultation to the jails, on an as needed basis, to improve

jail staffs response to deal with inmates with behavioral health needs. Regional Boards reported entering into more formal agreements with their local jails in thirty-one counties across the Commonwealth in FY 2004.

**STATE PERSPECTIVE**

Since the implementation of a multi-faceted legislative initiative in 1994, Kentucky has eliminated the use of jails during acute psychiatric crises and the involuntary hospitalization process. Instead, consumers are evaluated in emergency rooms or by staff of Regional MH/MR Boards. These efforts have:

- Increased understanding of mental illness by emergency responders such as ambulance drivers, paramedics, and peace officers;
- Improved access to evaluation and treatment;
- Improved communication among local peace officers, judges, mental health professionals, other community resources and the general public; and
- Reduced the stigma and trauma of involuntary hospitalization.

KDMHMRS has intensified efforts to build an integrated service system for individuals with serious and persistent mental illness who are involved in the criminal justice system. The need for collaboration among Kentucky's Divisions of Mental Health and Substance Abuse, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net" to serve persons with mental illness has become an increasingly apparent need.

In SFY 02, as the result of a series of investigative reports published in the Louisville Courier Journal related to suicides in local jails, the legislature appropriated $550,000 to KDMHMRS to develop a training curriculum for jail staff to address this issue. During SFY 03, KDMHMRS developed, implemented and monitored this training curriculum on suicide prevention and recognizing the signs and symptoms of mental illness. Regional board staff were trained in a "model curriculum" and then expected to train the staff in their local jails. In addition to this training, Regional Boards were encouraged to improve their working relationships with the local jails to assure mental health needs were being met for inmates housed in these facilities.

KDMHMRS will also be implementing a new project in local jails that establishes a behavioral health telephonic triage system. Funding was allocated in the 2004 legislative session to establish this system as well as fund the follow-up services that may be identified. The system includes the availability of a qualified mental health professional 24 hours a day, 7 days a week by telephone, to assess and make recommendations for housing, classification and treatment for individuals booked into jail who may have a mental illness, mental retardation, brain injury or be at risk of suicide.

KDMHMRS will continue to utilize block grant funds to partner with NAMI Kentucky to fund a cross-systems training coordinator during SFY 2003 (See Criterion Five). This position will continue to work across multiple systems (including mental health, mental retardation, substance abuse, corrections, criminal justice training, jailers association, and Kentucky State Police) to advocate for and coordinate training modules for first responders that encounter persons with behavioral health disabilities.

**Component 6: Care of Special Populations**

**This component describes the care provided for three special populations:**

- Persons who are aging
- Persons who are Deaf and Hard of Hearing
- Persons who have brain injuries

***Persons Who are Aging***

**REGIONAL PERSPECTIVE**

A review a regional SMI plans indicate that Regional MH/MH Boards are very much involved in activities related to the elderly, have mental health and aging coalitions and provide services to older adults. Approximately twelve (12) regions report that they have and provide support to a local mental and aging coalition. A majority of the support provided is having a designated staff person attend and participate in coalition activities. One region is involved with a Grandparent Support Group. Regions also provide material for training, sponsor training or have facilities available for meetings and training. Staff also present at coalition conferences.

A summary of types of services provided by the Regional MHMR Boards include:

- One Regional MH/MR Board provides Adult Day Health Care services in their entire region.
- Two regions provide In Home Services
- Thirteen (13) Regional MH/MR Boards provide mental health services in nursing facilities and personal care homes

Other services include: referral to private providers, public education regarding depression in the elderly, mental health and aging training conference, Caregiver support services, and education services on issues related to elderly and mental health.

Four (4) Regional MH/MR Boards report that they have a designated staff person/unit responsible for providing mental health services to older persons. Eight (8) Regions have older persons as representatives on the CMHC Board of Directors**.**

| Region | Plans For Development |
|---|---|
| 1 | Increase the penetration of SMI services to the aging population. |
| 2 | Ensure that persons who are aging are aware of services provided through the Pennyroyal Center |
| 5 | Increase Case Management services to aging population with SMI diagnosis. |
| 15 | Determine what service gaps exist for aging population who would reasonably be served within the mission of the organization. |

**STATE PERSPECTIVE**

In Kentucky, the elderly (over 60) population represents fourteen percent of adults with a severe mental illness who are served by Regional MH/MR Boards. In order to promote education, public awareness, and to improve services to the elderly, KDMHMRS has initiated a State Perspective mental health and aging coalition which was established in October of 1999. This coalition remains active and meets on a quarterly basis. The State Perspective coalition, Kentucky Mental Health and Aging Coalition, has provided funding to local regional coalitions in order to promote education, needs assessment, resource development and public awareness at the Local Perspective.

The KDMHMRS also provides training opportunities through the Mental Health Institute, PASRR Training and Case Management conference on an annual basis. Scholarships are offered to facilitate attendance at the Annual Summer Series on Aging Conference. In conjunction with UK OVAR GEC, the Department provides an annual statewide training to certified PASRR evaluators.

KDMHMRS has established partnerships with other agencies whose mission is to provide services and training for the elderly through serving on boards, task forces and Committees. The groups include but are not limited to: the Summer Series on Aging Planning Board, through the UK Sanders Brown Institute, Aging Work Group for House Bill 843, Alzheimer's Disease and related Disorders Council, and Kentucky KinCare Statewide Steering Committee.

The barriers as identified by the HB 843 Older Adults Work Group are a lack of interface between physical and behavior health care, transportation, provision of services in a variety of venues (in-

home, clinic site, nutrition site, senior center etc.) due to physical and medical disabilities, and lack of adequate funding for service to the older adult population.

The KDMHMRS priorities would be to continue to sponsor the Kentucky Mental Health and Aging Coalition and the HB 843 Aging Work Group in order to continue to encourage the development of public awareness, training, education and coordination of services for older adults at the state and in the Local Perspective.

***Services to Persons who are Deaf and Hard of Hearing***
**REGIONAL PERSPECTIVE**

**STATE PERSPECTIVE**
KDMHMRS employs a Statewide Coordinator for services to the deaf or hard of hearing. This position, in place since 1994, oversees all efforts to improve services for this population. In September 2002, a Program Coordinator was hired to work closely with the Statewide Coordinator. In response to the special accessibility problems of consumers who are deaf or hard of hearing, an Advisory Committee for Mental Health Services for the Deaf and Hard of Hearing was established by KRS 210.031 in 1992. Meeting on a quarterly basis and supported by these staff members, the advisory committee implements and monitors a variety of statewide and local consumer initiatives. Currently, there are 4 Masters level therapists fluent in sign language serving in 4 regions throughout the state and 1 case manager fluent in sign language in the Danville area.

The challenge to KDMHMRS to improve services to persons who are deaf or hard of hearing is contained in a report, “New Directions for Mental Health and Deafness,” prepared in June 1998 by consultants to the Advisory Committee and KDMHMRS. The report estimates that approximately 200 adults with severe mental illness, and 90 children with severe emotional disabilities, are deaf and will seek mental health services during a year. The recommendations from this report are listed in the GAP ANALYSIS.

The Department, the Regional MH/MR Boards, and the Legislature are responding to the challenge of the report. TTY devices have been installed in critical service sites throughout the state, including community mental health centers, state facilities and toll-free crisis lines. Individuals who are knowledgeable in deafness and mental health issues staff a statewide TTY Crisis Line. In addition to the providers, KDMHMRS staff has also received training in their use and in deaf awareness. Limited funds have been made available for interpreters, training and equipment to make local treatment more accessible. Interpreters are routinely available to facilitate the participation of consumers who are deaf or hard of hearing in meetings and conferences.

Kentucky Guidelines for Services for Deaf and Hard of Hearing, Late Deafened, and Deaf Blind People has been disseminated to all fourteen Regional MH/MR Boards; Rape Crisis Centers, domestic violence staff and substance abuse staff. The Guidelines have been revised and retitled “Kentucky Standards of Care for Deaf and Hard of Hearing, Late Deafened and Deaf Blind People”. The revised Standards of Care will be disseminated to all mental health service providers.

The Kentucky Deaf Access Consortium (KDAC) is a partnership between Eastern Kentucky University (EKU), the Department of Vocational Rehabilitation (DVR), KDMHMRS and the Kentucky Commission on the Deaf and Hard of Hearing (KCDHH). It is a consortium to support the four partners in expanding their capacities to serve the deaf and hard of hearing community with remote interpreting via videoconferencing. This consortium, through EKU, received a three-year federal grant in October of 2001.

***Services to Persons with Brain Injuries***
**REGIONAL PERSPECTIVE**

There are currently twenty-five active providers enrolled in the Acquired Brain Injury Medicaid Waiver program. Residential service providers are located in Ashland, Lexington, Louisville, Owensboro, and Paducah. While services are available in the most populous regions of the state, persons in rural communities often have difficulty obtaining the services of an enrolled provider.

Case management services are available statewide under the Traumatic Brain Injury Trust Fund program. Thus, access to financial assistance and case management services are available to eligible persons throughout the Commonwealth.

**STATE PERSPECTIVE**

In 1999, Kentucky initiated two programs serving persons with acquired brain injuries: the Traumatic Brain Injury Trust Fund; and the Acquired Brain Injury Medicaid Waiver program. Today these programs serve a combined total of approximately 1,800 children and adults – less than 1% of those who may be in need of services to overcome the effects of a brain injury.

There are currently two dedicated resources for children and adults with brain injuries in Kentucky: the Acquired Brain Injury Medicaid Waiver Program; and the Traumatic Brain Injury Trust Fund Program.

The Acquired Brain Injury Medicaid Waiver Program can serve 110 adults aged 21 to 65 years who meet nursing facility level of care, are financially eligible for Medicaid services, and who show the potential to progress. This intensive rehabilitation program offers fourteen services including case management, day program, supported employment, occupational therapy, speech and language therapy, counseling, behavior programming, companion services, personal care, residential, specialized equipment, environmental modifications, and respite care. The program is not intended to provide long-term care and its emphasis is on improving or restoring an individual's functioning. This program now has a waiting list of over 50 persons.

The Traumatic Brain Injury Trust Fund Program is designed to fill the gaps in service delivery that many people with brain injuries experience. To be eligible, an individual must have a brain injury and must have no other payer source for the needed service or supports, including wrap around services. Case management is provided to all recipients. Benefits to recipients are limited to $15,000 annually and $60,000 per lifetime. The cost of case management services is not deducted from the person's annual or lifetime caps. This program can serve approximately 1500 persons annually and now has a waiting list of over 600 children and adults.

**PERFORMANCE INDICATORS**

**1. Access to Targeted Case Management by Adults with Severe Mental Illness**

Value: Percent

Measure: Percent of estimated SMI adults who receive a TCM service based on federally established prevalence.

**2A. State Hospital Readmission of Adults with Severe Mental Illness / 30 Days**

This indicator has been refined to Adults with Severe Mental Illness (instead of all clients).

Value: Rate

Measure: Rate of re-admission of adults with severe mental illness (SMI) to an inpatient facility within 30 days of a previous discharge from the same facility, based on all admissions.

**2B. State Hospital Readmission of Adults with Severe Mental Illness / 180 Days**

This indicator has been refined to Adults with Severe Mental Illness (instead of all clients).

Value: Rate

Measure: Rate of re-admission of adults with severe mental illness (SMI) to an inpatient facility within 180 days of a previous discharge from the same facility, based on all admissions.

**Continuity of Care--Case Management**

Value: Percent

Measure: For adults with severe mental illness (SMI), percent of discharges from a state hospital who were referred for and received case management services by Regional MH/MR Boards.

**Continuity of Care--Outpatient Care**

Value: Percent

Measure: For adults with severe mental illness (SMI), percent of discharges who are seen for an outpatient appointment within 7,14 and 30 days after discharge from a state hospital

**Percentage of adults with severe mental illness and receiving community mental health services who are employed**

Value: Percent

Measure: Percent of adults with severe mental illness (SMI) served by Regional MH/MR Boards who are employed

**6. Percent of adults with severe mental illness and receiving community mental health services who are living independently**

Value: Percent

Measure: Percent of adults with severe mental illness (SMI) served by Regional MH/MR Boards who are Living Independently

**7. Outreach Rate -- Percent of adults with severe mental illness and receiving community mental health services who have contact with the justice system**

Percent

Value:

Measure: Percent of adults with severe mental illness (SMI) served by Regional MH/MR Boards who have contact with the justice system

**8. Outreach Rate -- Evidence Based Practices**

Value: Rate

Measure: The rate of MH/MR Boards that are utilizing Evidence Based Practices.

**9. SMI Adult Consumer Perception of Care**

Value: Percent

Measure: Percent of adults with severe mental illness (SMI) reporting positively about treatment outcomes.

See Appendix A: **PERFORMANCE INDICATORS**

**ACTIONS PLANS**

**Component 1: Consumer and Family Support**

The emphasis on recovery is recognized as a priority, and statewide initiatives will focus on issues that directly impact the lives of stakeholders. Initiatives in SFY 05 will include:

- Strengthening the education of consumers and family members about mental illness;
- Providing consumer wellness and recovery programs;
- Preparing consumers for responsible involvement in meaningful health planning at the state and regional levels;
- The development of consumer leadership within their local communities;
- Identifying Strategies and coordinating activities that involve mental health consumers and family members in state and regional planning and programs;
- Working collaboratively with NAMI KY and KY CAN on the consultative peer review process and training;
- Working collaboratively with NAMI KY and KY CAN to provide access and availability to technology for consumer and family members;
- Developing a brochure about grievance procedures;
- Improving access to "Ticket to Work" and other employment initiatives; and
- Maintaining communication with consumer and family advocates

❖ **State Objective A-1-1:** Support the Peer Review process coordinated by KY CAN

**Component 2: Outpatient Mental Health Services**

***Emergency Services***

KDMHMRS is committed to assuring that each Regional MH/MR Board serves as the " safety net" for persons with mental illness who may be in crisis. The foundation for the establishment of a responsive, effective, and efficient crisis response system of care is currently built upon the 24-hour crisis telephone services and the availability of qualified mental health professionals to screen persons for involuntary psychiatric hospitalization.

A flexible array of crisis services is needed in each region in order to meet the diverse needs that consumers in crisis may be experiencing. For this reason, KDMHMRS is very interested in outcomes related to the recent development of a more flexible crisis stabilization service in one region of the state. This region created a " flexible crisis stabilization program" by utilizing their allocation for a crisis stabilization unit to fund four crisis case managers (who are available 24 hours a day, 7 days a week), as well as to purchase crisis beds in various locations in their region.

<u>Specific Needs Identified</u>:

- Additional Crisis Case Management Staff
- Assertive Community Treatment
- Additional Mental Health Professional to Evaluate persons voluntary hospitalization after hours
- Additional Crisis Stabilization beds
- Additional training for first responders
- Additional funding would be needed to assure a full array of crisis services in each region.

Currently KDMHMRS is re-evaluating the role of crisis stabilization units in each region. Kentucky is experiencing a reduction in private psychiatric bed availability, in addition to a reduction in funding for our state operated and state contracted hospitals. As the number of inpatient psychiatric beds continues to be reduced, the role of crisis stabilization units becomes even more critical to meeting the needs of persons with mental illness who may be experiencing a crisis.

- **State Objective A-1-2:** Assist Regional MH/MR Boards in implementing and monitoring crisis stabilization programs thorough statewide technical assistance meetings.
- **State Objective A-1-3:** Assist Regional MH/MR boards and local jails in the development, implementation and monitoring of behavioral health jail telephonic triage system.

***Continuity of Care/ Reduction in Inpatient Psychiatric Care***

Despite slow, incremental improvement in some key performance indicators (aftercare within 14 and 30 days), most indicators are showing no positive change. A few hospital districts have shown more change than others. Some of this may be attributed to the relationship of the hospital to the state (whether run directly or contracted).

With the gradual reduction in private psychiatric hospital beds, admission rates to state psychiatric hospitals have risen during the last year. Average daily census hit dramatic highs at Western State Hospital this year (again partially attributable to a reduction of over 100 beds in the private psychiatric hospital sector).

KDMHMRS will continue to use a variety of strategies designed to improve continuity of care. These are described earlier in this section. Of critical importance, however, is the relationship between state hospital discharge staff, Regional MH/MH Board staff and other players in the local system of care (homeless service providers, crisis stabilization programs) and the development of effective protocols for providing seamless service delivery for individuals transitioning to the community.

- **State Objective A-1-4**: Assure the development of Memorandums of Understanding between state operated/state contracted hospitals and Regional MH/MR Boards.

***Mental Health Treatment***

In addition to providing funding, KDMHMRS and the Regional Boards use the following strategies to insure that integrated mental health treatment services are available as consistently as possible across Kentucky's fourteen mental health regions:

- Supporting the use of new assessment software applications such as LOCUS to insure consistent assessment of levels of care;
- Promoting the use of evidence-based treatment guidelines such as medication algorithms and dialectical behavior therapy;
- Recruiting of Advanced Registered Nurse Practitioners (ARNPs) who can prescribe medications in association with a psychiatrist;
- Establishing standards for insuring continuity of care across treatment settings.
- Mandatory training for all adult service case managers and their supervisors includes a two-hour training session on co-occurring disorders.
- The Kentucky School for Alcohol and Drug Studies and the Mental Health Institute provide training on co-occurring disorders for consumers, family members and providers.

- **State Objective A-1-5:** To promote integrated treatment for persons with co-occurring disorders, provide at least one statewide training opportunity on Motivational Interviewing techniques.

**Component 3: Specialized Services for Adults with Severe Mental Illness**

***Case Management***
Although adult case management services are available in all 120 counties in the state, access to services is inconsistent and sometimes inadequate to meet the need. The statewide average in SFY 2003 for access to targeted adult mental health case management was 7.5%, ranging from 3.6% in one region to 21.1% in another.

The delivery of quality, timely case management services continues to be challenged by a number of factors including:

- The current billing system considers four contacts per month a unit of service. Contacts above or below this figure are not reimbursed;
- Kentucky Medicaid rates for case management were capped during SFY 03 and continued to be capped in SFY 04 (due to deficits in the overall state Medicaid program); and
- Turnover among case managers is high; in general case managers have less status than outpatient clinicians and this "service" is often viewed as an entry level position.

Identified priorities include:

- Increased access to effective case management services and resources.
- Access to effective case management training and supervision including best practices technology in both the basic mandated core training and workshops offered at the annual case management conference.
- Planning and participation in regulatory changes regarding the targeted case management regulation.
- Promotion of best practices such as Assertive Community Treatment.

❖ **State Objective A-1-6:** Develop a pilot project for web-based Case Management Training by June 30, 2005.
❖ **State Objective A-1-7:** Develop Case Management Standards of Care in collaboration with DMHMRS, DMS, CMHC's, consumers, and family members.

***Rehabilitation Services***
Identified priorities include:

- Dissemination of information about evidenced based practices including psychiatric rehabilitation and supported employment to community support program directors with stakeholder meetings established to support adoption of a consistent and effective statewide model.
- Access to effective rehabilitation and supported employment training and supervision including best practices technology in community support program director meetings and the annual mental health institute.
- Planning and participation in regulatory changes regarding the community mental health center regulation.
- Utilizing data from the Multnomah Community Ability Scale (MCAS) for program evaluation to be distributed to the CSP directors.

Strategies include:

- Provision of initial and ongoing technical assistance and consultation to regional CSP directors and TRP directors;
- Planning and coordination of the quarterly community support program directors meeting to include best practice information, support, and collaboration.
- Partnership with advanced training opportunities such as the annual mental health institute training;
- Coordination and implementation of a Kentucky Recovery Initiative to transform our rehabilitation service system to a recovery oriented system of care through a time-framed plan with stakeholder participation; and
- Promotion of evidence-based or "best" practices (such as supported employment, psychiatric rehabilitation, and integrated treatment);

- An additional strategy that has been very successful is the sponsorship of regional staff in securing their International Association of Psychosocial Rehabilitation Services (IAPSRS) credentials. In SFY 03, 30 regional staff and 18 in SFY 04 availed themselves of the opportunity to take the IAPSRS test. It has been a goal of the DMH to increase the number of certified rehabilitation staff at the local level.

❖ **State Objective A-1-8:** Implement the Multnomah Community Ability Scale functional assessment tool for all adults identified as SMI within the regional MH/MR Board treatment system in SFY 05.

**Component 4: Housing**

The Department embraces a "Supported Housing" approach to providing housing options for adults with severe mental illnesses. Supported Housing involves the linking of affordable, permanent, community-based housing options with flexible services and supports. It also assumes that individuals have preferences and should be involved in choosing where and with whom they live. CMHS Block Grant funds have been critically important to the development of affordable housing while promoting linkages with housing related supports such as skills training, assistance in securing subsidies, and housing search activities.

KDMHMRS strategies to increase the percentage of consumers who live independently include:

- Establishing an email newsletter to disseminate housing information to statewide contacts;
- Promoting rental assistance program development;
- Providing training events on supportive housing and the subsidized housing delivery system;
- Participating in HB 843 and Olmstead planning activities
- Providing technical assistance to local nonprofit housing developers through referral to KHC's Supportive Housing Specialist.

❖ **State Objective A-1-9:** Support the development of additional supportive housing units in the state by collaborating with the Kentucky Housing Corporation, the Housing and Homeless Coalition in Kentucky, the Council on Homeless Policy, and other key state housing organizations in the two-year Corporation for Supportive Housing initiative.

**Component 5: Systems Interface**

***Physical Health System***

While Medicaid provides a significant benefit for physical health care for many individuals with severe mental illness, many still do not have access to care. Individuals still visit hospital emergency rooms for routine physical health care. Other challenges include:

- Inability to afford costly physical health medications;
- Lack of follow-up by consumers with prescribed health regimens for chronic conditions (e.g. diabetes, heart disease);
- Limited formal agreements between primary care settings and Regional Boards; and
- Few examples of physical health and mental health service integration

KDMHMRS encourages the use of formal or informal agreements between Regional Boards and local primary health care providers. It also monitors for the quality of care provided in assessing and arranging for the treatment of physical health conditions among individuals with mental illnesses. Ultimately, the development of performance indicators is necessary to insure that a consistent level of attention to physical health care needs is provided.

❖ **State Objective A-1-10:** Identify a methodology to assess the strength of the partnership between Regional Boards and their local health department.

***Criminal Justice System***

Ideally a full array of diversion and reentry programs would be available in communities to effectively serve adults with mental illness who interface with the Criminal Justice System. Specialized training for law enforcement utilizing the Crisis Intervention Team model, Mental

Health Courts and reintegration planning are vital components in the development of interventions to reduce the likelihood of a person with severe mental illness cycling between the two systems.

Effective diversion and reintegration programs do put an increased burden on local providers since persons with severe mental illness are diverted into the mental health system rather than continuing to move into the criminal justice system. In times when resources are limited, many boards have struggled with finding effective ways to serve this challenging population.

The lack of a clearly identified funding source for jail based mental health care has been a long-standing barrier in the Commonwealth. One stipulates that the local jail is responsible for the payment of mental health care; another states that the Commonwealth is responsible for the payment of this service. The passage of HB 157 and the establishment of the telephonic crisis network for local jails will improve communities' ability to identify and to treat individuals with severe mental illness who interface with the criminal justice system.

- **State Objective A-1-11** Design and implement a sustained training program for Regional MH/MR Board staff and their criminal justice collaborators on 202A / crisis triage, targeting issues related to co-occurring disorders.

**Component 6: Care of Special Populations**

***Persons who are Aging***

To continue to promote public awareness and education of the mental health needs of older adult the following objective was chosen.

- **State Objective A-1-12:** Fund at least two local aging coalitions to provide public awareness and education activities.

***Persons who are Deaf and Hard of Hearing***

Existing Barriers/Challenges to service delivery to this population includes:

- Funding sources;
- Qualified staff proficient in sign language; and
- Culturally appropriate mental health services.

KDMHMRS has identified the following areas for future development:

- Establish residential treatment program for deaf children;
- Inpatient mental health units for adults and children who are deaf and experiencing acute mental illness;
- Psychiatric/substance abuse inpatient treatment program;
- Hiring a case manager, interpreter and Masters Level therapist as a "team" concept for each quarter of the state;
- Manage mental health interpreting services under a single statewide contract that is coordinated by the state mental health agency;
- Accessible housing for people who are deaf and have a mental illness; and
- Deaf therapeutic foster homes.

- **State Objective A-1-13:** KDMHMRS will provide at least one training in each of the state operated or state contracted facilities.

***Persons with Brain Injuries***

The Traumatic Brain Injury Trust Fund Board of Directors (the Board) initiated a strategic planning process by establishing a planning work group in February 2004. The planning group included

stakeholders from across the brain injury community, including persons with brain injury, family members, service providers, and state agency personnel.

The Strategic Plan is designed to serve as a road map for the development of services and as a tool for responding to the continuously changing needs of citizens of the Commonwealth whose lives have been forever altered by an acquired brain injury. There are four broad goals in this strategic plan. The objectives under each goal are specific activities that will lead to the accomplishment of the goal. The plan outlines goals and objectives for a five-year period, and is an evolving document that the Board will review annually. The established goals are:

- **State Objective A-1-14:** Seek legislative action to require helmets when riding bicycles, motorcycles, and ATVs, as well as legislation rendering the failure to use seat belts as a primary offense.

The Traumatic Brain Injury Trust Fund Board of Directors is now working with the Cabinet for Health and Family Services toward the adoption of the Strategic Plan as the template for the further development of services for persons with brain injury in the state.

**Comments from the Mental Health Planning Council meeting on August 19, 2005:**

**A-1-1**: Comment: How will targets for client satisfaction be established?
*Response: There are some national benchmarks for client satisfaction and some Centers are already doing client satisfaction and have ideas about reasonable targets.*
Comment: Suggestion was made that KY-CAN make a presentation to the Council on Peer Review Process at a future Council meeting. The twenty-eight item MHSIP will be used.
*Response: This will be arranged*.
Comment: Recovery Network of Northern Kentucky is not mentioned by name in the Adult plan, although they receive block grant funding.
*Response: Revision will be made to ensure Recovery Network of Northern Kentucky is included by name.*

**A-1-2**: Comment: Council member asked about the source of funds for jail triage and training
*Response: An additional $5.00 in court costs is the source of funding. It is not state general funds, it will be "agency fees." We anticipate revenues of $2.5 million annually. These funds will be distributed to county jails based on the number of jail beds, not utilization of the service or fees collected by a particular county.*
Comment: It is up to the jailer then as to whether they use the service or not?
*Response: Yes, but we worked with jailers and their insurance underwriters to show them that it is in their best interest to utilize the services and lower their risk.*
Comment: This means that the marginalized will be paying for this service as they are the ones in court.
Comment: Does it help with medications for those in jail?
*Response: No, it does not cover medications.*

**A-1-3**: Comment: Does our plan talk about a recovery-oriented model over a medical model?
*Response: Yes, definitely we are moving all programs towards a recovery model and this is stated in our goal statement for this Criterion.*
Comment: I think perhaps we need a stronger statement in the plan that we are using Recovery Model.
*Response: Noted by planners.*

**A-1-5**: Comment: Regarding the proposed web-based case management training, comment was made that we still need face-to-face training for new Case Managers.
*Response: Yes, we agree but the on-line initial training would allow Centers to train staff as soon as they are hired with essential information and then the "live" training can be shorter so there is not as much cost to Centers for travel, etc.*

Comment: What's the turnover rate of Case Managers? It is so difficult to have to change case managers over and over (as a consumer/family member).
*Response: Certainly, higher than we would like. We are always trying to raise the status of case management as a service and that of case managers in hopes of reducing turn over.*

**A-1-8**: Comment: Is the functional assessment tool (Multnomah) to be filled out by hand or on computers?
*Response: Clinicians fill out hard copies right now but we hope to be web based-soon to improve the turn around time for getting the data back to clinician/treatment team.*
Comment: Are case managers able to complete the assessments also or just clinicians?
*Response: That is a decision left to the Regional Boards but many of them do have case managers to do the assessments because they often know the client well and are able to conduct a thorough assessment.*
Comment: It is so essential to have this data with the recovery model.
Comment: It is important that the data all be collected in the same way as well.
*Response: Training for all staff is the same and is focused on making sure there is consistency in the administration of the tool.*

**A-1-9**: Comment: Kentucky has done very well with regard to housing for consumers.
*Response: Block Grant funds support a staff position at KHC (Jim Sparks). Don Ball, building contractor from Lexington, is Chairman of the Board at KHC and he is a strong advocate for SA/MH services.*
Comment: Do you think they will ever bring the 1% homeownership loans back for SMI?
*Response: I don't think so but grants towards principal reduction is somewhat similar and is available.*

**A-1-11**: Comment: Will we get this done this year (accomplish all the training that is stated in the objective)?
*Response: Yes, we plan to*.
Comment: How many mental health courts do we have (in KY)?
*Response: Jefferson County has a mental health docket. Judges want mental health training rather than more courts. We have drug courts and family courts and there is not great support for adding MH courts.*
Comment: Unless you get judges to volunteer it will never happen but NAMI and CIT are educating judges.
Comment: Aren't we better served by jail diversion than mental health courts?
*Response*: *Ideally we need a whole array of services from jail diversion to MH courts to reintegration services. The Department supports the earliest possible type of intervention in the process.*
Comment: We need pre-booking education so the mentally ill don't get a felon label.
Comment: Jail triage will help because the jailers can back up and discuss with prosecutors and judges and will divert after jailing might drop charges and divert.

Comment: Must train consumers also contact with consumers in non-emergency setting between jailers and consumers helped greatly.
Comment: Frankfort police department wanted more officers to participate in virtual reality training.
Comment: Make sure to include consumers as trainers like done in the past. It was very beneficial to have the consumers' testimonies.
*Response: Yes, we plan to have them involved as we have in the past.*

**A-1-12**: Comment: Who are the two local coalitions (on aging)?
*Response: There are nine but some are active and some are not. State Planner will revise grid in Adult Criterion 1 to reflect all the aging coalitions.*

**A-1-13**: Comment: I'm hard of Hearing and I think this is a very well kept secret as a consumer I am finding out about available services by reading this plan. I really think we need a peer advocate in every region because the work is not getting out about all the services in our communities. Also, I think so many times the people are reaching are the SMI in the Therapeutic Rehabilitation (TR) programs so those not attending TR are missing out on available services.
Comment: We have an 843 workgroup working on Public Education/working with the media. You may wish to call and join this workgroup.
Comment: The KYCares web site needs to be promoted Dept. should help promote.
*Response: It is cited in the Plan.*

**A-1-14**: Comment: Kentucky needs a helmet law!

**Criterion 2: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data**

***This plan describes how quantitative population targets are to be achieved through the implementation of the mental health system, including estimates of the numbers of individuals with severe mental illness in the state (or prevalence rates) and the numbers of such individuals served.***

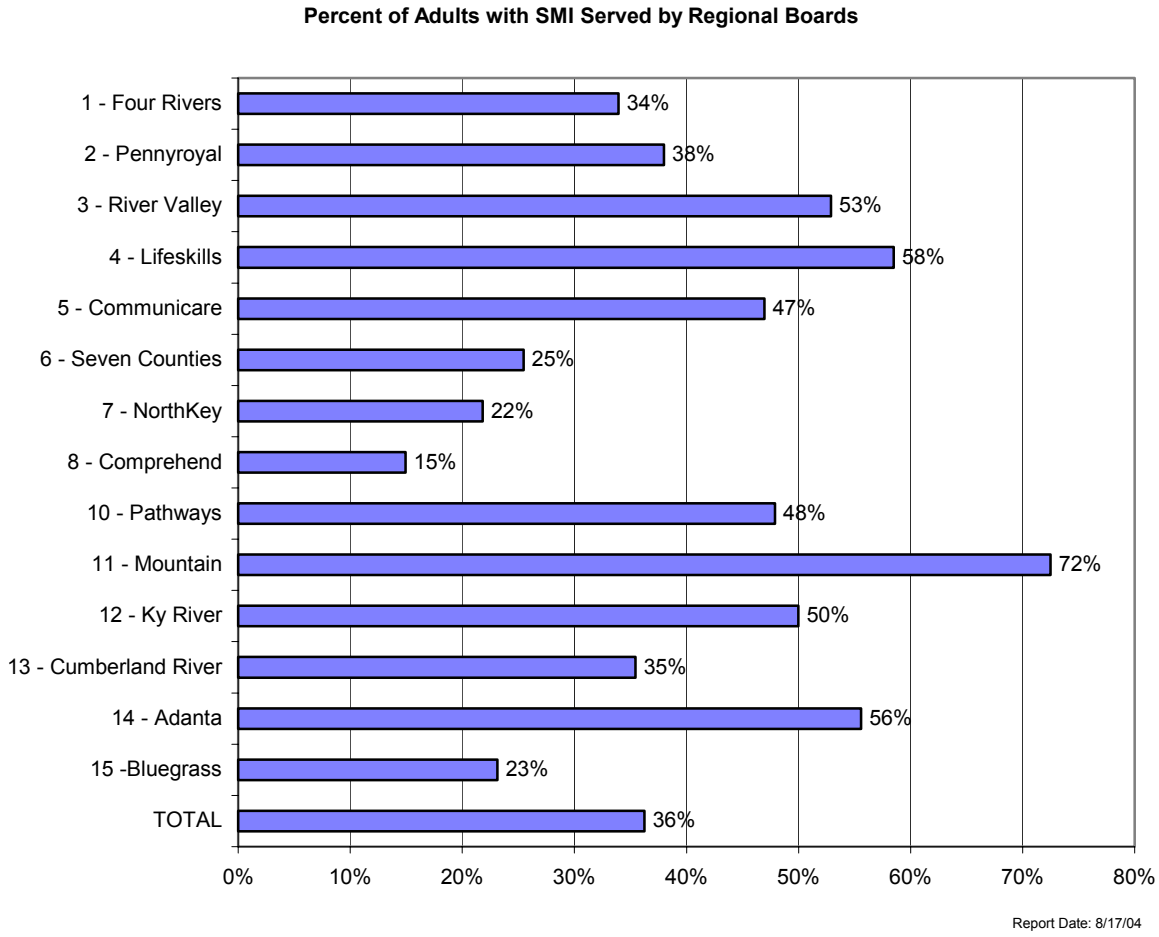
**Goal: To increase access to services for adults with severe mental illness.**

**Component 1: SMI Prevalence**

**REGIONAL PERSPECTIVE**

The following table uses the federal SPMI prevalence rate and 2000 census data to estimate, by mental health region, the number of Kentucky adults with SPMI using the federal definition. That estimate is compared to the number of unduplicated adult clients with severe mental illness served by the Regional MH/MR Board during SFY 2004. A resulting regional penetration rate is calculated.

| Regional MH/MR Boards | Adult Census 2000 | Federal SPMI Estimation | Kentucky SMI Adults Served | Penetration Rate |
|---|---|---|---|---|
| Four Rivers | 157,510 | 4,095 | 1,389 | 34% |
| Pennyroyal | 154,361 | 4,013 | 1,524 | 38% |
| River Valley | 155,001 | 4,030 | 2,132 | 53% |
| Lifeskills | 193,083 | 5,020 | 2,936 | 58% |
| Communicare | 177,804 | 4,623 | 2,171 | 47% |
| Seven Counties | 654,224 | 17,010 | 4,335 | 25% |
| NorthKey | 286,137 | 7,440 | 1,624 | 22% |
| Comprehend | 41,452 | 1,078 | 161 | 15% |
| Pathways | 162,796 | 4,233 | 2,027 | 48% |
| Mountain | 121,476 | 3,158 | 2,289 | 72% |
| Kentucky River | 91,201 | 2,371 | 1,185 | 50% |
| Cumberland River | 177,872 | 4,625 | 1,639 | 35% |
| Adanta | 147,152 | 3,826 | 2,127 | 56% |
| Bluegrass | 526,882 | 13,699 | 3,169 | 23% |
| **TOTAL** | **3,046,951** | **79,221** | **28,708** | **36%** |




**Regional Plans For Development**

| Region | Plan for Development |
|---|---|
| **2** | Increase penetration rate for adults with SMI by 3%:<br>• Provide training to RESPOND staff to enable them to better identify and target SMI clients into service in a timely manner.<br>• Review process for recognizing and properly coding individuals as SMI upon intake. Hold at least two trainings within the fiscal year. |
| **3** | Train business office staff on proper coding of priority populations. |
| **5** | To provide additional education to professional staff and perform chart reviews on a quarterly basis to check on the marking of target populations. |
| **6** | Monitor penetration rates four times a year. |
| **7** | To improve overall penetration rate to the SMI population by at least 5% over the FY'04 performance:<br>• Add the SMI marker check off to the annual psychosocial update.<br>• Train staff on the importance of accurately reflecting number of SMI clients served. |
| **8** | Increase SMI penetration rate to 25% to 30% in FY 2005:<br>• Inventory all processes and procedures with respect to SMI identification<br>• Update policies and procedures, practice management software, clinical and clerical. |
| **9/10** | Review coding methods with MIS Department. |
| **11** | Increase the Penetration Rate of adults with Severe Mental Illness by 10%:<br>• Increase case management availability by adding at least 1 case manager. |

| | |
|---|---|
| | • Clinical and support staff will receive training in appropriate coding and diagnosing. |
| **12** | Complete synthetic estimation project to estimate SMI prevalence for every county and region in Kentucky using Epidemiological Catchment Area Project diagnostic prevalence estimates:<br>• Complete writing estimation algorithms<br>• Publish results and present to Mental Health Institute and/or KDMHMRS officials. |

**STATE PERSPECTIVE**

Kentucky's earliest estimates of the prevalence of severe mental illness were based on national work. In 1980, the U.S. Department of Health and Human Services (USDHHS) estimated that 3.14 percent of the population had some level of mental disorder, and that 0.75 percent of the population had a mental disorder that causes prolonged disability.

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for "adults with severe mental illness." CMHS was further required to develop an "estimation methodology" based on the definition that state mental health agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by the definition. The federal definition of "adults with a severe mental illness" was published on May 20, 1993.

Early planning in Kentucky for adults with severe mental illness, using the 0.75 prevalence rate for adults with persistent disability, estimated that approximately 28,000 adults in Kentucky should be the priority population for services. Kentucky's mental health planning has historically focused on this subset of the population in development of its Community Support Services plan.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of "chronic mental illness"; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with severe mental illness consistent with national policy.

Kentucky's definition of "adult with severe mental illness," as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration:

Kentucky's definition is more narrow than the definition promulgated in the federal register for "Adult with Severe and Persistent Mental Illness." Historically, stakeholders have supported the Department's desire to focus limited funding on adults who meet the state's narrower definition.

| Variable | Criteria |
|---|---|
| **AGE** | ❑ Age 18 or older |
| **DIAGNOSIS** | ❑ Major Mental Illness<br>• Schizophrenia (DSM 295.xx, 297.1, 298.9)<br>• Mood Disorder (296.xx)<br>• Other (DSM _____) within State and Federal Guidelines for Severe Mental Illness |
| **DISABILITY** | ❑ Clear evidence of functional impairment in <u>two or more</u> of the following domains:<br>• Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.<br>• Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.<br>• Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture.<br>• Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.<br>• Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating. |
| **DURATION** | ❑ One or more of these conditions of duration:<br>• Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years.<br>• The individual has been hospitalized for mental illness more than once in the last two- (2) years.<br>• There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time. |

The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with severe mental illness, and a rate of 2.6 percent for adults with severe and persistent mental illness (SPMI).

**Component 2: Mental Health Systems Data**

**REGIONAL PERSPECTIVE**

At the local Regional MH/MR Board level, outcome instruments are being used for program evaluation, identification of staff training needs, and client treatment planning. Consumers, Regional quality assurance staff, Community Support Program directors and Department staff have cooperated in the development of useful reports from the outcomes data. These reports will soon become available on the Department's web site for their use.

**STATE PERSPECTIVE**

The Cabinet for Health and Family Services, as part of the Executive Branch strategies statewide, is moving toward performance-based contracting. Therefore, the Department continues planning with its primary contractors, the Regional MH/MR Boards, to measure and manage organizational performance and clinical/personal outcomes. The Regional Boards remain essential partners with the Department, as well as with consumers, families, and advocates, in identifying what outcomes need measuring, what instruments are appropriate for measuring those outcomes, and

what resources are required for implementing the measures. A significant amount of outcomes data collection occurs now as a result of that collaboration. The improvement of these data sets and the addition of new measures will complement what is already in place.

For over ten years, the Department has been building a system to structure and house data. Within this system, the Department continues to review and improve the quality of datasets collected monthly from Regional MH/MR Boards and the state hospital facilities. These datasets include:

- Client, Event, and Human Resources data from Community Mental Health Centers
- State hospital facility Admission and Discharge Data

This Data Infrastructure Grant Project allows the Division of Mental Health to drive the Department's performance indicators towards real-life outcomes measurements by helping to improve the data currently being collected and by implementing new outcomes measurements. To date, the Regional MH/MR Boards have worked with the Division of Mental Health to set national precedents in the area of performance indicators. The goal of the Division is to continue to expand and relate these indicators into real-life outcome measures. The result of having outcomes data is an increase performance of the organizations providing services and the improvement of the lives of Kentuckians receiving mental health services.

The Division of Mental Health has been addressing the issue of outcomes for the two main populations they serve: Adults and Children. The following addresses specific outcomes initiatives within the Adult Mental Health Services arena*:*

- *Brief Psychiatric Rating Scale (BPRS) for Crisis Stabilization Consumers (currently in use)*
  Administered upon consumer admission and discharge.
- *Multnomah Community Ability Scale and the Medical Outcomes Study Health Status Survey for SMI consumers.*
  Administered upon client admission and at consequent six-month intervals.
  Implementation of the use of the instrument will extend over a three-year period. The selected population will be consumers of Therapeutic Rehabilitation Services in the first year, will expand to include consumers of Case Management Services in the second year and expand to all remaining SMI consumers in the third year.
- *University of Kentucky Behavioral Health Satisfaction Tool for Outpatient Consumers*

  This tool includes three instruments:
- *Kentucky Consumer Satisfaction Survey;*
- *The 21 item Mental Health Statistics Improvement Program Survey; and*
- *Medical Outcomes Study Health Status Survey.*
  Annually administered to 5 percent of consumers served

  Medical Outcomes Study Health Status Survey
  Completion of this tool is voluntary for consumers who have severe mental illness and are served through Therapeutic Rehabilitation Programs.

**PERFORMANCE INDICATORS- Criterion 2**

**1A. Penetration Rate--Adults with Severe Mental Illness**

Value: Percent

Measure: Percent of adults with severe mental illness (SMI) who received community mental health services.

**1B. Penetration Rate--Older Adults with Severe Mental Illness**

Value: Percent

Measure: Percent of older adults with severe mental illness (SMI) who received community mental health services.

See Appendix A: **PERFORMANCE INDICATORS**

**ACTION PLANS**

**Criterion 2**

**Component 1: SMI Prevalence**

A review of the information from the SFY 05 regional plans reveal that:

- All fourteen regions described their process for coding SMI.
- Only two regions exhibit variances of more than one standard deviation from the statewide average (penetration rate) and are actually higher than the statewide average. This is an improvement over last year when one-half of the regions were out of range (more than one standard deviation from the statewide average).

From the wide variation of penetration rates, it is evident that the SMI marker in the KDMHMRS data set is not consistently applied. The Department has an interest in applying a consistent definition of "adults with severe mental illness" to improve the quality of information on this priority population. Accuracy of coding is monitored by medical record reviews during periodic Status Assessments of mental health services provided by Regional MH/MR Boards.

In addition, statistical indicators that rely on the number of adults with an SMI marker are increasingly used to assess performance and outcomes. As a result, Regional MH/MR Boards and the Department are increasingly interested in the consistent and accurate use of the marker in their data sets.

As the KDMHMRS moves toward the use of performance indicators and performance contracting, the issue of identifying individuals with severe mental illness in clinical records and in the client data set becomes increasingly important.

Regional MH/MR Boards have adopted a number of strategies to more accurately identify individuals as meeting the KDMHMRS definition of severe mental illness. These include:

- Increased training of clinicians
- Routine chart reviews
- Changes in intake and update procedures

❖ **State Objective A-2-1:** Continue to collaborate with Regional MHMR Boards in exploring their processes for accurately and consistently identifying adults with severe mental illness who receive community mental health services.

**Component 2: Mental Health Data**

*Uniform Reporting System*

Kentucky can report overall 62% completion and 38% partially completed on the 21 tables. Figure 1 provides a glance at the status of Kentucky reporting in the Uniform Reporting System tables. The majority of the 38% partially completed tables pertain to evidence-based practice information. In recognizing the need for continued assistance in this area, SAMHSA has developed a workgroup to study further what evidence-based practice information is needed at the Federal level and what related evidence-based practice information states can submit. This workgroup has stated that the information requested in the current evidence-based practice tables may change in the upcoming years. Kentucky will make every effort to attain the

information as requested in the tables. One step toward doing so is that our State Planner participates in the Evidence-Based Practice Workgroup conference calls.

*Quality Assurance*
Currently, the Division of Mental Health has a process that facilitates information exchange and maintains continuity and relational values among data sets. The Joint Committee on Information Continuity (JCIC) is the committee that establishes policies and procedures for this purpose. The structure of the Division of Mental Health currently does not include a compatible committee for establishing procedures for Quality Assurance as related to outcomes. Quality Assurance is developed and maintained at individual project levels. Project level management would be more efficiently served by having a Committee in place to serve all projects.

*Resources Needed to Implement Evidence-Based Practices*.
Currently, additional resources are needed to support more extensive use of clinical evidence based practices. Kentucky currently does not have in clinical practice several evidence based practices as listed in the Uniform Data Reporting System.

*Costs*
Processes developed for applying the BPRS and the MCAS are in place so that instrument usage stands alone of any further shrinking of available resources. The application of the MHSIP Consumer Survey is currently being conducted as a result of the Data Infrastructure Grant. Kentucky will plan to work with Regional MH/MR Boards to set in place a process to annual collect and process the MHSIP survey data as well as reduce the Boards' costs of having to meet related JACHO requirements.

*Identification of Clients*
Currently, the Cabinet can not identify clients served in order to conduct quality performance surveys such as the MHSIP Consumer Survey. Having access to this information means further working with the contracted Regional MH/MR Boards and adjusting data base structures to include this information.

*Data Warehouse*
Linking mental health data with other agency data such as public health, education, or justice system currently requires project level Memorandum of Agreements. Kentucky would like to work toward establishing a data warehouse to make available information to agencies who share common goals.

*Analysis of Multiple Data Sets*
The Division of Mental Health and Substance Abuse is working with the Department for Community Based Services (DCBS), the Department for Public Health, Department of Corrections and the Department for Juvenile Justice to develop methods for sharing data without breaching confidentiality. Utilization of private psychiatric hospital beds by Regional Board clients is a major subject for analysis during the coming fiscal year. Comparison of data on children by DCBS and children served by KDMHMRS is also planned to assist DCBS in complying with their federally-recognized Performance Improvement Plan. Additionally, involvement in the criminal justice system by adults and children is the subject of another study. These efforts are part of the federally funded "Data Infrastructure Grant" project.

*Uniform Reporting System*
Kentucky is applying for the State Data Infrastructure Grant in order to accomplish the three objectives:

- To be able to complete 100% of Uniform Reporting System tables (21) by September 2007.
- To continue to improve the quality of the data submitted by the Providers (14 Regional MH/MR Boards). This includes continued work with the Research and Data Management Center and the Joint Committee for Information Continuity to improve data reporting in the

areas of accuracy and completeness. This also includes regular consultation with a group of Quality Improvement Specialists.

- To further develop outcomes goals within the Division of Mental Health. In addition to having access to the completed Uniform Reporting System data tables, the Division has established performance measures for use understanding the effectiveness of service delivery across Kentucky. The next step is using this information in developing a deeper understanding and improvement of service delivery. The Division would like to be able to make further use of the variables collected to benefit community-based delivery systems. The first step includes setting outcomes goals.

*Quality Assurance for Outcomes*

- The first step to assuring quality outcomes begins with goal three in the above section related to the establishment of Division-wide outcome goals. Secondly, The Department will plan to establish a committee for establishing procedures for Quality Assurance as related to outcomes. This committee will most likely involve consumers, Regional MH/MR Boards, and Department staff.

❖ **State Objective A-2-2:** KDMHMRS will monitor the MIS for accurate reporting of data.

**Criterion 4: Targeted Services to Homeless and Rural Populations**

***The plan provides for the establishment and implementation of outreach to, and services for, such individuals who are homeless and the manner in which mental health services will be provided to individuals residing in rural areas.***

***Goal: Improve outreach and services to persons who are homeless or live in rural areas of the Commonwealth***

**Component 1: Homeless Outreach**

**REGIONAL PERSPECTIVE**
Most Regional MH/MR Boards offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Regional MH/MR Boards report in their system of care plans for adults with severe mental illnesses the following level of participation:

- All Regions participate in regional Continuum of Care routine meetings;
- All Regions give a service priority to homeless individuals;
- Seven Regions have staff dedicated to homeless individuals;
- Two Regions do street outreach;
- Seven Regions regularly visit local homeless shelters;
- Nine Regions do consultation with local shelters; and
- Nine Regions have a walk-in clinic.

**STATE PERSPECTIVE**
By combining PATH and other McKinney funds (that support specialized services) with state and federal funds (that support Community Support Services), KDMHMRS and the Regional MH/MR Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with severe mental illness who are homeless. The role of the State PATH Coordinator is central to supporting local PATH providers throughout Kentucky. The Coordinator prepares the annual PATH application in collaboration with local providers, insures that annual data collection requirements are met, and insures that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homeless issues, and on-site technical assistance as needed.

KDMHMRS collaborates with the Specialized Housing Resources Department within the Kentucky Housing Corporation (KHC) in the maintenance of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen mental health regions). Regional MH/MR Boards are encouraged to participate in this process for the benefit of individuals with severe mental illness who may be or become homeless in their regions.

The Department provides state funds to the St. Johns' Day Center in Louisville to hire an outreach worker. This staff person provides on-site assessment and links individuals with services at Seven Counties Services, the Regional MH/MR Board for Louisville. During SFY 05, CMHS Block Grant funds will continue to support a Rural Homeless Outreach program in the Mountain Regional MH/MR Board area. The goals of this program will be the identification and linkage of individuals with serious mental illness who are homeless with mainstream mental health services and the provision of consultation and training to homeless service providers. The service providers will primarily be members of the region's Continuum of Care group charged with developing regional, collaborative strategies to serve the homeless

KDMHMRS is also collaborating with the Kentucky Council on Homeless Policy that has developed a Statewide Homeless Prevention Plan. This plan is designed to adopt policies and

strategies to improve access to mainstream services for people experiencing homelessness. Recommendations include such areas as:

- Coordination of services;
- Planning Strategies;
- Procedural processes;
- Training needs; and
- Funding

Work has begun (and will continue in SFY 05) to craft a ten-year plan to end chronic homelessness in Kentucky. Staff within the Division of Mental Health and Substance Abuse are playing a principal role in identifying barriers to receipt of mainstream mental health and substance abuse services by individuals who have been chronically homeless.

**Component 2: Rural Outreach**

**REGIONAL PERSPECTIVE**

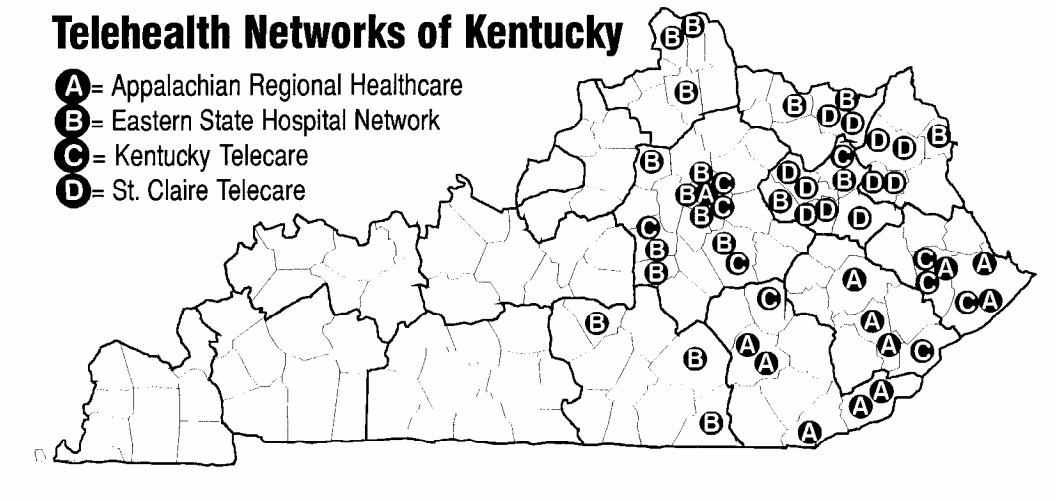
A number of initiatives have been established at the Regional Board level to address rural issues. CMHS Block Grant funds continue to be allocated to rural areas to maintain housing developer positions. These staff persons are responsible for improving access to existing housing as well as developing additional housing opportunities for adults with severe mental illness. Rural housing developers have been focusing on applying for and administering set-asides of rental assistance funding to be targeted to adults with mental illness residing in rural counties. A number of housing funding sources have been accessed including HOME funds, Emergency Shelter Grant funds and Shelter plus Care funds. These initiatives have allowed Regional Boards to tailor rental assistance programs to local needs.

Nine of fourteen Regional MH/MR Boards report engaging in initiatives to better coordinate transportation services in their regions. The Bluegrass Regional MH/MR Board maintains a teleconferencing/telepsychiatry network across the four regions within the Eastern State Hospital district. Telehealth is used for discharge planning meetings between ESH and outpatient offices. The University of Kentucky is also using telemedicine to communicate with local clinics in Eastern Kentucky. An initiative of the 2000 Kentucky General Assembly established a Telehealth Board, which established standards and enabled billing for telehealth services.

Four Regional MH/MR Boards now report delivering or accessing services from the telehealth network and for very limited uses (e.g. screening for case management services upon discharge from state facilities).

- Comprehend, Inc., reports that quarterly continuity of care meetings are provided from ESH to participating CMHC's and that plans call for more intensive utilization of this technology, including the provision of psychiatric services in their Lewis County office.
- Kentucky River Community Care, inc., has several sites equipped for video conferencing. Two sites are a part of the Appalachian Regional Healthcare network and one site is a part of the Centernet network. They have business meetings, Olmstead meetings, case conferences, trainings and other events over these networks but have not started providing direct client services over these networks since protocols have not yet been established.
- Bluegrass Regional MH/MR Board has provided telehealth services in the past, and are finalizing billing instructions to enable an expanded use of this service. Bluegrass also utilizes trainings from the University of Kentucky's TeleHealth network for continuing education of staff and general grand rounds.

A map showing the availability of “telehealth” in eastern Kentucky, where access is most problematic, may be found below.

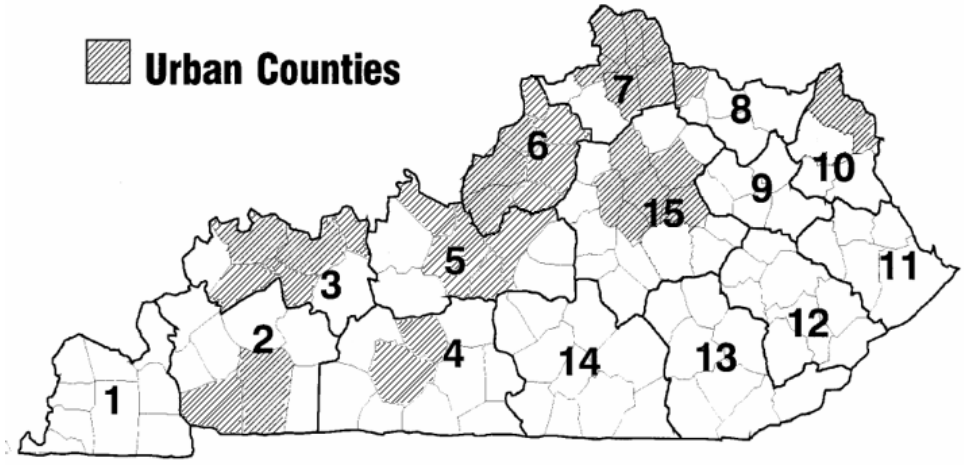



**Regional Plans For Development**

| Region | Plan for Development |
|---|---|
| 2 | Pennyroyal MH/MR Board, Inc., plans to establish outreach clinics in Crittenden and Trigg counties. |
| 6 | Seven Counties Services, plans to recruit and hire one additional case manager for the rural sites to increase capacity for outreach, and two aide positions to provide transportation to the 2 rural Therapeutic Rehabilitation programs. |

**STATE PERSPECTIVE**

Using the definition of Standard Metropolitan Statistical Area, and information from the 2000 Census, Kentucky has 35 counties considered urban and 85 considered rural. Approximately 44% of the state's population resides in its 85 rural counties. Population distribution is shown in the chart below.




**Estimated Adults with SMI in MHMR Regional Boards**

| Region Number | Urban 2000 | 2.6% of | Rural 2000 | 2.6% of |
|---|---|---|---|---|

| | Census Adult | Adult Pop | Census Adult | Adult Pop |
|---|---|---|---|---|
| 01 | 0 | 0 | 157,510 | 4,095 |
| 02 | 61,517 | 1,599 | 92,844 | 2,414 |
| 03 | 126,109 | 3,279 | 28,892 | 751 |
| 04 | 80,023 | 2,081 | 113,060 | 2,940 |
| 05 | 123,851 | 3,220 | 53,953 | 1,403 |
| 06 | 654,224 | 17,010 | 0 | 0 |
| 07 | 270,699 | 7,038 | 15,438 | 401 |
| 08 | 6,164 | 160 | 35,288 | 917 |
| 10 | 67,104 | 1,745 | 95,692 | 2,488 |
| 11 | 0 | 0 | 121,476 | 3,158 |
| 12 | 0 | 0 | 91,201 | 2,371 |
| 13 | 0 | 0 | 177,872 | 4,625 |
| 14 | 0 | 0 | 147,152 | 3,826 |
| 15 | 314,851 | 8,186 | 212,031 | 5,513 |
| Total | 1,704,542 | 44,318 | 1,342,409 | 34,903 |

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of 16 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number.

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens, church groups, and government agencies. Rural case managers have been resourceful in assisting persons with a severe mental illness in identifying their needs, as well as meeting these needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Several actions by the Kentucky General Assembly have increased the types and numbers of mental health professionals who can be Qualified Mental Health Professionals and created licensure for mental health counselors. The KDMHMRS will continue to work with rural communities and other entities in these activities including addressing shared federal, state, and local funding, shared and cross training, and bringing all stakeholders together at the state and Local Level to strategize best practices.

The advantages of establishing a teleconferencing capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, teleconferencing can be used to extend staff coverage from a central site to outlying rural clinics and other service sites. Specialized services (e.g. therapists who are fluent in sign language) could be effectively extended through the use of teleconferencing.

Simplified Access to Commonwealth Service provides resource access via the Internet. Consumers, family members and providers can access the website at www.KyCARES.net and obtain information on any number of physical health and behavioral health services.

During SFY 05, statewide consumer and family initiatives will continue to receive CMHS Block Grant funding to continue to impact on the problems associated with rural isolation, stigma, lack of information and access**:**

- The Mental Health Association of Northern Kentucky will provide education, information and training outreach on stigma in rural areas;
- The Kentucky Consumer Advocacy Network's Bridges Program will continue to provide peer support in several rural areas; and
- NAMI Kentucky will provide "Family to Family" education in eight or more rural counties. A statewide campaign with the faith community has been developed to heighten awareness of the special needs of families and consumers in rural areas. In addition, the Crisis Intervention Team program will be expanded to include rural areas.
- NAMI Kentucky will target two rural areas for establishment of new local affiliate organizations.

**PERFORMANCE INDICATORS**
**Criterion 4**

1. **Outreach Rate--Homeless Adults with Severe Mental Illness**
   Value: Percent

   Measure: Percent of adults with severe mental illness (SMI) served by Regional MH/MR Boards who are Homeless.

2. **Penetration Rate--Rural Adults with Severe Mental Illness**
   Value: Percent

   Measure: Percent of the estimated number of adults with severe mental illness who live in rural counties who received a community mental health service.

See Appendix A: **PERFORMANCE INDICATORS**

**STATE ACTION PLANS**

**CRITERION 4**

***Homeless Outreach***
Given a prevalence estimate of 79,221 persons with serious and persistent mental illness in Kentucky (2.6% of the population, by federal methodology) and a rate of 3.2% of homelessness among persons with serious and persistent mental illness (SPMI) in the public mental health system, it is estimated that there are approximately 2,559 persons with SPMI who experience homelessness in Kentucky (at some point in time during a 12 month period).

| Region | Homeless | Mission/Shelter |
|---|---|---|
| 01 | 13 | 13 |
| 02 | 8 | 0 |
| 03 | 16 | 33 |
| 04 | 20 | 13 |
| 05 | 8 | 1 |
| 06 | 295 | 105 |

| | | |
|---|---|---|
| 07 | 136 | 77 |
| 08 | 1 | 2 |
| 10 | 23 | 0 |
| 11 | 0 | 0 |
| 12 | 8 | 2 |
| 13 | 6 | 0 |
| 14 | 32 | 0 |
| 15 | 77 | 39 |
| **State Total** | **643** | **285** |

| Regional MH/MR Boards | Adult Census 2000 | Federal SPMI Estimation | Homeless SPMI Estimation |
|---|---|---|---|
| 1. Four Rivers | 157,510 | 4,095 | 132 |
| 2. Pennyroyal | 154,361 | 4,013 | 130 |
| 3. River Valley | 155,001 | 4,030 | 130 |
| 4. Lifeskills | 193,083 | 5,020 | 162 |
| 5. Communicare | 177,804 | 4,623 | 149 |
| 6. Seven Counties | 654,224 | 17,010 | 549 |
| 7. NorthKey | 286,137 | 7,440 | 240 |
| 8. Comprehend | 41,452 | 1,078 | 35 |
| 10. Pathways | 162,796 | 4,233 | 137 |
| 11. Mountain | 121,476 | 3,158 | 102 |
| 12. Kentucky River | 91,201 | 2,371 | 77 |
| 13. Cumberland River | 177,872 | 4,625 | 149 |
| 14. Adanta | 147,152 | 3,826 | 124 |
| 15. Bluegrass | 526,882 | 13,699 | 442 |
| **Total** | **3,046,951** | **79,221** | **2,559** |

The Kentucky Council on Homeless Policy has identified the following barriers to decreasing homelessness.

- Lack of knowledge about the types of resources and process for access;
- Difficulty in keeping existing databases and information sources up to date;
- Non-uniform accessibility to resources in each region;
- No central point of contact for becoming aware of or accessing available resources either at the state or local level;
- No shared philosophy among all social service workers of prevention approach; and
- "Mainstreaming" homeless persons with severe mental illness into regular mental health programs and other community services operated by Regional MH/MR Boards and other community agencies.

Additional barriers include:

- No state funds are provided for homeless services;
- Limited residential options that combine permanent housing with on-site supports;
- Although Kentucky received an increase in PATH funding, to $352,000, it is insufficient to address the needs of homeless persons with mental illness in the state.

Priorities identified by the Kentucky Council on Homeless Policy and KDMHMRS include:

- Continued participation in HUD's Continuum of Care process, with increased coordination between agencies;
- Continued outreach to homeless persons with a mental illness;

- Decrease discharges from inpatient facilities to homeless shelters; and
- Expansion of the state PATH program.

During SFY 05 KDMHMRS will, through the PATH Formula Grant, support specialized initiatives to complement the existing community support array in the three urban regions (Lexington, Louisville, and Covington) and two rural regions (Kentucky River and Adanta). PATH programs will provide the following services:

- Outreach, housing, case management and psychiatric clinic services in a large homeless shelter in Lexington;
- Outreach, housing and psychiatric clinic services in Covington;
- Payeeship and case management services within a homeless service organization in Covington;
- Residential support within a transitional facility for homeless men with severe mental illness in Louisville;
- Case management and residential support in the Kentucky River Region; and
- Outreach and housing support services in the Adanta Region.

KDMHMRS staff and Regional MH/MR Board staff use a number of strategies to insure that individuals with serious mental illnesses who are homeless are evaluated and receive necessary services. These include:
- Identifying individuals who have been homeless more accurately in the client data set;
- Providing accommodations in clinic and other program hours;
- Providing specialized training to case managers and clinicians;
- Establishing formal and informal linkages with homeless services providers; and
- Continued participation in local Continuum of Care meetings.

❖ **State Objective A-4-1:** Continue to encourage the strengthening of the relationships between homeless providers and state facilities utilizing the Quarterly Continuity of Care Meeting.

***Rural Outreach***

The President's New Freedom Commission on Mental Health recommends improving access to quality care in rural and geographically remote areas. The Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnosis (HB 843) recommends addressing the issues of transportation, the availability of trained professionals, and the availability and utilization of telehealth and distance learning technology to reduce the isolation in rural areas.

Common problems for rural areas are isolation and the difficulties imposed by the lack of information and access. Lack of adequate transportation, and in some regions, lack of any public transportation remains the largest barrier to services. Other problems include the heightened stigma associated with mental health services in rural areas and the difficulty in ensuring confidentiality and anonymity in small communities. Regional Planning Councils of the HB 843 Commission identify a lack of sufficient funding and a scarcity of trained professionals as barriers to services in their regions.

Priorities include:
- increasing access to services by increasing transportation opportunities;
- increasing availability of trained treatment professionals;
- increasing public awareness of mental health services; and
- increasing availability and utilization of telehealth to reduce isolation.

❖ **State Objective A-4-2:** Incorporate best practices in rural service delivery into existing KDMHMRS sponsored training events (e.g. MHI, CSP Director, Level II Case Management**).**

**Comments from the Mental Health Planning Council meeting on August 19, 2005:**

**A-4-1**: Comment: Are there no state funds used for services for the homeless?
*Response: No, we have PATH grant that is allocated to the regions.*

**Criterion 5: Management Systems**

***The plan describes the financial resources and staffing necessary to implement the requirements of such plan, including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health. The plan contains a description of the manner in which the state intends to expend the grant for FFY 2004 to carry out the provisions of the plan.***

***Goal: To assure that the recovery oriented mental health system has:***

- ***An adequate number of mental health professionals***
- ***A culturally competent workforce***
- ***Adequate and appropriate training of mental health professionals***
- ***Adequate financial resources***

**COMPONENT 1: Staffing Resources**

**REGIONAL PERSPECTIVE**

Community mental health services in Kentucky are provided by Regional MH/MR Boards, which are non-profit corporations employing approximately 4000 persons statewide. A small segment of this workforce works exclusively with adults with severe mental illnesses in community support programs. In the recent Plan and Budget submission, Regional MH/MR Boards were asked to identify staff dedicated to serving adults with severe mental illnesses.

These Community Support Program (CSP) staff include the following:

| Region | SMI Served | Case Mgmt. | Therapeutic Rehabilitation | Outpatient Therapists | Total Dedicated CSP Staff |
|---|---|---|---|---|---|
| 1 | 861 | 6 | 5 | 19 | 11 |
| 2 | 1471 | 8 | 5 | 20 | 13 |
| 3 | 1623 | 9 | 14 | 4 | 18 |
| 4 | 2532 | 16.5 | 14 | 51 | 30.5 |
| 5 | 692 | 7 | 17 | 3 | 27 |
| 6 | 4959 | 52 | 9 | 49 | 110 |
| 7 | 1618 | 6 | 8 | 12 | 14 |
| 8 | 219 | 3 | 5 | 16 | 8 |
| 9/10 | 1874 | 12 | 61.7 * | 61.7 * | 77.7 |
| 11 | 2170 | 24 | 24 | 17 | 66.5 |
| 12 | 1290 | 12 | 15 | 6 | 28 |
| 13 | 1160 | 9 | 13 | 75.5 | 22 |
| 14 | 2132 | 17 | 28 | 42 | 45 |
| 15 | 3163 | 19.8 | 46.72 | 179 | 280 |

*Combined total of TR and Outpatient staff.

**Regional Plans For Development**

| Region | Plan for Development |
|---|---|
| **1** | Attain an 85% Clinical Practitioner retention rate. |
| **2** | Provide internships for two pre-doctoral psychology students interns and 2 MSW interns who will be potential staff members at the completion of their education. |
| **13** | Review staffing patterns and allocations. |

**STATE PERSPECTIVE**

Human resource development is a key component in crafting a quality system of care. The issue of "staffing" is affected by a number of factors including regulations, provider qualifications, training, recruitment and retention. Although the Department does not directly employ or manage the staff of the Regional MH/MR Boards, the Department is responsible for planning for a workforce to meet the demand for services. Traditionally the Department's role has been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications for providers. The Department continues in these roles but has taken on a larger, more direct role in addressing the shortage of behavioral health care providers in the state.

**Component 2: Cultural Competency**

**REGIONAL PERSPECTIVE**

All Regional Boards offer some form of cultural competency training to their staff. Most provide this as part of their orientation period for new employees. While many access the Department's cultural competency training opportunities (and subscribe to a train-the-trainers approach), some engage outside consultants to provide staff training.

**Regional Plans For Development**

| REGION | PLAN FOR DEVELOPMENT |
|---|---|
| 1 | No goal related to cultural competency |
| 2 | All staff are to receive cultural competency training.<br>At least four staff will be certified as cultural competency trainers. |
| 3 | No goal related to cultural competency |
| 4 | Conduct a needs assessment related to cultural competency training.<br>Provide training based on the outcome of the needs assessment. |
| 5 | All Community Support Programs are to receive cultural competency training. |
| 6 | Survey staff regarding training needs.<br>Provide most requested training. |
| 7 | Increase the competency of staff in serving those individuals with co-occurring disorders. |
| 8 | Provide cultural competency training to at least 90% of staff. |
| 10 | Increase awareness among staff as to the growing Hispanic population within the region.<br>Hire interpreters to aid in serving Hispanic clients. |
| 11 | At least 50% of Community Support Program staff will receive cultural competency training. |
| 12 | No goal related to cultural competency |
| 13 | No goal related to cultural competency |
| 14 | Increase the competency of staff in serving those individuals with co-occurring disorders. |
| 15 | Provide cultural competency training to all clinical staff within their first month of employment.<br>Update the agency's cultural competency training curriculum. |

**STATE PERSPECTIVE**

As our communities grow more diverse, this is certainly an area of interest and concern for the Department for Mental Health and Mental Retardation Services. In order to provide the best mental health services to our consumers, we must have a competent and diverse workforce. That diversity is not just seen in the areas of age, gender, race, ethnicity, religion, color, national origin, disability, and sexual orientation, but is also relevant to work experience, personality, geographic origin, and ability and skill levels.

All of us are challenged to develop our competencies in working with people of cultural heritages different from our own. The purpose of these trainings and seminars is to increase awareness of cultural issues and develop a level of competency appropriate for the administration of state mental health programs at the state level. That level incorporates a set of behaviors, attitudes and policies that enable professionals to work effectively in cross-cultural situations.

In an effort to enhance that competency across the state, the Department offers specialized "*Training of Trainers*" (TOT) to centers and facilities. This training consists of two full days where participants become equipped to provide the same training to their staff. Also offered are one day '*Topical Seminars'* on various diversity issues that keep staff current in the cultural competency field.

To this end, the Department contracts with two highly acclaimed cultural competency trainers to provide "Training of Trainers" courses at least twice a year to staff from Regional MH/MR Boards and facilities. These courses are based on a continually evolving curriculum developed by the Department and are held at varying locations throughout the state. This strategy has been very favorably received by the Regional MH/MR Boards and facilities as it allows them to develop their own internal cultural competency training capacity, as well as minimizing out-of-office time on the part of staff and related travel expenses.

**Component 3: Major Training Initiatives**

**REGIONAL PERSPECTIVE**

A review of the information from the SFY 04 regional plan applications reveals that:

- Twelve of the Regional Boards offer specialized training opportunities to CSP staff;
- Five Regional Boards now have 21 staff that have earned IAPSRS certification; and
- Ten regions have ongoing training initiatives with local colleges or universities that are described in their annual plans.

As one component of the "decriminalization" of mental illness, each Regional MH/MR Board is responsible to provide education programs to peace officers, emergency service providers, courts, and inpatient psychiatric facilities in their region. Topics included are an overview of the involuntary hospitalization law, the consumer's need for privacy, the importance of using the least restrictive level of restraint, and how to access evaluators 24 hours a day, seven days a week. A curriculum based on the initial decriminalization training for peace officers is included in the yearly training provided to each peace officer in Kentucky, and is included in the training of adult protective service workers for the Cabinet for Families and Children.

**Plans for Development**

Regional MH/MR Boards submitted the following plans in this area:

| Region | Plan |
|---|---|
| **1** | Advocate to retain CEU allocation, despite budget item vulnerability. |
| **2** | The Pennyroyal Center Staff Executive Team will develop a plan for mandated training for employees and seek CEU credits. |
| **3** | Incorporate training in annual budget for CSP staff. |
| **4** | Continue to provide for adequate staff training necessary to maintain licensure/certification. |
| **5** | Work with Lindsey Wilson College to develop a plan to offer Masters Level Social Work courses within the region. |
| **6** | SCS will provide quarterly in-service trainings for the SMI staff. |
| **7** | Each Adult Services employee will identify with his/her supervisor at least one training need for the upcoming year on the annual performance evaluation. The employee will attend in-service training to fulfill these training needs. |
| **8** | Comprehend will work with the new Master's degree program being offered in the fall at Northern Kentucky University. |

| | |
|---|---|
| **9/10** | Send staff from every county to MHI. |
| **11** | To provide continuing training to 100% of CSP staff using the Boston University Technology. |
| **12** | During the upcoming biennium KRCC will work with state and regional committees on the development of specialized training program/s for the Kentucky River Region. |
| **13** | Continue to collaborate with local universities in providing master level programs leading to certification/licensure in the behavioral health services. |
| **14** | Maintain current level of training. |
| **15** | During FY 04 employees working with Therapeutic Rehabilitation Programs will be targeted for training opportunities. The goal will be for 100% of direct care staff working in a TRP program to receive a minimum of 8 hours job specific training in addition to the clinical supervision hours and mandatory organizational training already provided. |

**STATE PERSPECTIVE**

KDMHMRS provides, sponsors, or participates in a variety of training initiatives. This includes sponsoring continuing education units (CEUs) for professional board licensure and certification. Many of these initiatives have been referenced in preceding sections but are discussed in detail here

On an annual basis the Division of Mental Health provides a number of training events. These include:

| **Type of Training** | **Intended Audience** | **# of Participants** | **Frequency** |
|---|---|---|---|
| Case Management Certification Training | Prospective providers of Adult Targeted Case Management services | Approximately 15-25 per session | Four times per year |
| Mental Health Institute | Behavioral health providers, consumers and family members | Approximately 1,000 | Annually |
| Case Management /Service Coordination Conference | Providers of Adult and Children's Targeted Case Management services | Approximately 125 | Annually |
| Jailer Training | Jailers and Regional MH/MR Board staff | Approximately 400 | Annually |
| PASRR Training | Regional MH/MR Board staff who will be conducting PASRR evaluations | Approximately 15 | Annually |
| Office of Consumer Advocacy Leadership Academy | Consumers of mental health services | Approximately 30 | Annually |
| Cultural Competency Training of Trainers | Current and prospective providers of Cultural Competency Training at the KDMHMRS operated or contracted facilities and Regional MH/MR Board staff | Approximately 20 | Two times per year |
| Community Support Services Training | Directors of Regional MH/MR Board Community Support Programs | Approximately 15 | Quarterly |
| Deaf Awareness Trainings | Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central | Ranges from 5-125 per session | Typically once per month and also on a PRN basis |
| TTY Assistive | Behavioral health service | Ranges from 5-125 | Typically once per |

| | | | |
|---|---|---|---|
| Listening Devices Training | providers, state operated or contracted facilities, consumers, local interest groups and central | per session | month and also on a PRN basis |
| What Is Mental Health Training | Kentucky Association for the Deaf | Up to 200 | Annually |
| Domestic Violence and Deafness Training | Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central | Approximately 60 | Annually |
| HIV/AIDS Training | Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central | Ranges from 5-125 per session | Annually |

**Case Management Certification Training**
This certification training is provided by KDMHMRS and Kentucky Medicaid staff with the assistance of consumers, family members and staff from Regional MH/MR Boards. The training is provided four times per year, in two regions of the state. To assist with the development and implementation of case management training activities, a Case Management/Service Coordination Advisory Committee, composed of a faculty of case managers, supervisors, consumers, family members, and advocates, was developed in 1993. This advisory committee meets quarterly and provides vision, technical assistance, training opportunities, curriculum development, and direction for mental health case management services in Kentucky. An additional training curriculum has been developed and expanded to include advanced courses for the experienced case manager (Level II) and specialized training for case management supervisors.

**Mental Health Institute**
The Department hosts an annual conference called the Mental Health Institute for approximately 1,000 Regional MH/MR Board providers, family members, and consumers. The Institute is a major source of continuing education for behavioral health professionals employed by the Regional MH/MR Boards.

**Case Management/Service Coordination Conference**
In recognition of the critical role of targeted case managers in Kentucky's system for delivering comprehensive community-based services to adults with severe mental illness and children with severe emotional disabilities, KDMHMRS, with the State Interagency Council for Children with an Emotional Disability, sponsors an annual Case Management/ Service Coordination Conference. The Case Management/Service Coordination Advisory Committee plans, hosts and staffs this annual conference.

**Jailer Training**
During SFY03 the Department received new state funding to train staff in each of the 85 jails in the Commonwealth in mental health issues.

**PASRR Training**
The Department sponsors PASRR certification training for staff of the Regional MH/MR Boards who provide PASRR Level II evaluations for persons seeking admission to nursing facilities. The Department also sponsors PASRR skills training through a contract with the University of Kentucky Sanders-Brown Center on Aging.

**Leadership Training Institute**

The Office of Consumer Advocacy sponsors a Leadership Training Institute for consumers who want to develop their leadership potential. They are nominated by KY CAN and Regional MH/MR Board staff.

**Cultural Competency Training**
The Department sponsors cultural competency "train-the-trainers" sessions twice per year for interested Regional MH/MR Board and facility staff. The training uses a curriculum developed in SFY 97. Additionally, two seminars targeted for KDMHMRS central office staff are also provided on an annual basis.

**Community Support Services Training**
KDMHMRS staff convenes quarterly meetings of directors of Community Support Services programs and staff. These meetings and other training events are ideal settings for the provision of innovative training in evidence based practice and technical assistance from state and national experts in the areas of rehabilitation and recovery, continuity of care, housing, crisis response systems, dual diagnosis and more.

**Deaf and Hard of Hearing Training**
The KDMHMRS Statewide Coordinator for Deaf and Hard of Hearing Services, along with a new Program Coordinator staff member, continue to provide on-going statewide training, technical assistance and consultation regarding the provision of mental health services and communication with persons who are deaf or hard of hearing. Continued training of Deaf awareness and correct TTY usage is also provided. Additionally, training to inform and empower the deaf and hard of hearing community regarding their rights to services and how to obtain needed, appropriate services is ongoing. Accessing and using technology remains an important aspect of all contacts with providers and consumers.

**Training of Emergency Services Personnel**
To build on this successful initiative, KDMHMRS uses Block Grant funds to partner with NAMI Kentucky to fund a cross-systems training coordinator. This position works across multiple systems (including mental health, mental retardation, substance abuse, corrections, criminal justice training, jailers association, and Kentucky State Police) to advocate for and coordinate training modules for police officers that encounter persons with severe and persistent mental illness. This position is also developing training curriculums for other first responders including emergency medical responders and judges.

**Component 4: Financial Resources**

**REGIONAL PERSPECTIVE**
As described already in the Context section, mental health block grant funds represent a little over 3% of all revenues available to the Regional MH/MR Boards. Given the current fiscal crisis, the Boards have had to withstand a 2.5% across the board reduction in state funding this year. Of primary concern to the Boards is maintenance of safety net services for the hardest to serve populations. This is made more difficult as the majority of revenue received from the state has been flat funded for over 10 years.

**STATE PERSPECTIVE**
KDMHMRS does not provide direct community-based services, but assures the delivery of services through contracts with the fourteen Regional MH/MR Boards.

CMHS Block Grant funds are subcontracted by the Department to the Boards based on an approved Plan and Budget. The Plan and Budget is the basis for the contractual agreement between the Department and a Regional Board to provide services that are consistent with fund

source requirements, departmental priorities, service definitions and standards. Regional MH/MR Boards may subcontract with appropriate community agencies to provide the contracted services.

**New Appropriations for SFY 2005-2006**

- Jail Triage - $2.5 million

**SFY 2005 Financial Resources Summary – Adult Services**

The following table summarizes the financial resources available for SFY 2005 to support the comprehensive array of adult mental health services:

| **SFY 2005 ALLOCATIONS** | |
|---|---|
| **Fund Source** | **Amount** |
| Restricted MH General Fund & Decriminalization | $12,033,611 |
| Flexible MH General Fund & Community Care Support | $13,512,554 |
| CMHS Block Grant | $3,916,596 |
| PATH | $352,000 |
| PASRR | $1,066,900 |
| Community Medications | $5,373,100 |
| Personal Care Homes (MHGF) | $7,445,666 |
| Housing | $1,016,901 |
| Acquired Brain Injury | $2,470,662 |
| Olmstead Wraparound | $800,000 |
| Other Federal funds | $332,888 |
| Medicaid | $50,520,942 |
| Other Local | $14,956,246 |
| **Total Adult Allocations** | **$113,798,066** |
| Funds allocated for services to either Adults or Children ($769,924) are not included in the above total. | |

SFY 2005 CMHS Block Grant Allocations

The following table illustrates CMHS Block Grant allocations for services to adults with severe mental illness in SFY 2005 listed by the components of the array discussed in Criterion 1:

| **Component** | **Block Grant Amount** |
|---|---|
| Consumer and Family Support | $724,903 |
| Crisis Services | $219,357 |
| MH Treatment | $122,572 |
| Case Management & Outreach | $1,374,129 |
| Housing Options | $668,855 |
| Rehabilitation Services | $591,700 |
| Other (Training, Planning, etc.) | $215,080 |
| **Total SMI** | **$3,916,596** |
| CMHS Block Grant Funds allocated to CMHCs for services to either Adults or Children ($133,088) are not included in the above total. | |

SFY 2005 Funded Entities – Adult Services

*The table below shows SFY 2005 CMHS Block Grant funding by funded entity.*

| **TABLE A** | |
|---|---|
| **Region/Contract** | **Amount of Adult CMHS Award for SFY 05/FFY 04** |
| *1 – Four Rivers* | $136,201 |
| *2 – Pennyroyal* | 183,823 |
| *3 – River Valley* | 201,443 |
| *4 – LifeSkills* | 283,435 |
| *5 – Communicare* | 149,778 |
| *6 – Seven Counties* | 998,555 |
| *7 – NorthKey* | 312,515 |
| *8 – Comprehend* | 35,731 |
| *10 – Pathways* | 234,822 |
| *11 – Region XI (Mountain)* | 182,607 |
| *12 – Ky River* | 80,045 |
| *13 – Cumberland River* | 251,551 |
| *14 – ADANTA* | 124,853 |
| *15 – Bluegrass* | 430,856 |
| *KHC* | 13,333 |
| *Corrections* | 50,000 |
| *Voc Rehab* | 75,000 |
| *EKU* | 172,048 |
| **TOTAL** | **$3,916,596** |
| *Funds allocated to provide MH services For either Adults **or** Children (not included above)* | $133,088 |

A list of funded entities is provided on the following page. These entities will be funded with FFY2004 and FFY2003 carryover consistent with priorities of the Mental Health Services Planning Council and the Department's plan and budget process.

**Funded Entities**

**Regional MH/MR Boards**

Region 1
***Four Rivers MH/MR Board, Inc.***
1526 Lone Oak Road
Paducah, Kentucky 42003

Region 2
***Pennyroyal Regional MH/MR Board, Inc.***
P O Box 614
Hopkinsville, Kentucky 42241-0614

Region 3
***River Valley Behavioral Health***
P O Box 1637
Owensboro, Kentucky 42302-1637

Region 4
***LifeSkills, Inc.***
P O Box 6499
Bowling Green, Kentucky 42101-6498

Region 5
***Communicare, Inc.***
1311 North Dixie Avenue
Elizabethtown, Kentucky 42701

Region 6
***Seven Counties Services, Inc.***
101 W. Muhammad Ali Blvd.
Louisville, Kentucky 40201

Region 7
***NorthKey Community Care***
P O Box 2680
Covington, Kentucky 41012

Region 8
***Comprehend, Inc.***
611 Forest Avenue
Maysville, Kentucky 41056

Region 9/10
***Pathways, Inc.***
P O Box 790
Ashland, Kentucky 41100

Region 11
***Mountain Comp. Care Center***
150 South Front Avenue
Prestonsbug, Kentucky 41653

Region 12
***Kentucky River Community Care***
P O Box 794
Jackson, Kentucky 41339-0794

Region 13
***Cumberland River Comp. Care Center***
P O Box 568
Corbin, Kentucky 40702

Region 14
***The ADANTA Group***
259 Parkers Mill Road
Somerset, Kentucky 42501

Region 15
***Bluegrass Regional MH/MR Board, Inc.***
P O Box 11428
Lexington, Kentucky 40574

**Other Funded Entities**

***Eastern Kentucky University***
100 Stratton Building
Richmond, Kentucky 40675

***Kentucky Housing Corporation***
1310 Louisville Road
Frankfort, Kentucky 40601

**PERFORMANCE INDICATORS**
**Criterion 5**

**1. Community Service Proportion of State Mental Health Funding**

Value: Percent

Measure: Percent of KDMHMRS mental health funds allocated for regional, non-institutional programs.

**2. Per Capita State Mental Health Expenditures**

Value: Rate (dollars per Kentuckian per year)

Measure: KDMHMRS mental health dollars for institutional and community programs per

Kentuckian.
See Appendix A: **PERFORMANCE INDICATORS**

**STATE ACTION PLANS**

**Component 1: Staffing Resources**
A number of trends and challenges make recruiting and retaining a quality workforce motivated to work in CSP programs a difficult process:

- Low pay for CSP staff, compared with outpatient clinicians;
- Lower status associated with the rehabilitation field;
- Lack of a career ladder;
- Lack of specialized training opportunities that directly relate to one's job duties;
- Limited standards of care in the CSP program; and
- Limited master's level programs in rural areas.

The Department's strategies in insuring that the workforce is well trained have been to:

- Provide inexpensive in-service training;
- Establish linkages with universities to promote pre-service and in-service training and to facilitate recruitment;
- Develop staff certification programs in the areas of case management and geriatric assessment and to offer an extensive curriculum in the basics of clinical practice; and
- Encourage the employment of a diverse and qualified work force that is culturally competent and representative of minority persons.

The Department has worked with the state Department of Personnel to identify policies and procedures that impede the recruitment and retention of qualified staff. An agreement between the Department and the state Department of Personnel allows Regional MH/MR Boards to receive names and addresses of eligible persons seeking employment in mental health professions.

Several mechanisms for collecting data are becoming available to KDMHMRS in our on-going efforts to ascertain the supply and demand of Human Resources statewide and to improve the recruitment and retention of mental health professionals within the state. Among them are:

- HB 843 Regional Planning Council's needs assessments;
- A study prepared for the HB 843 Commission on the availability of licensed and certified behavioral health professionals in Kentucky;
- The Olmstead State Plan Committee's strategies for collecting and improving outcomes data; and
- Strategies developed at a regional "Provider Summit" meeting attended by Kentucky representatives in November, 2000.

As a result of the HB 843 process, regional needs assessments provide a basis for assessing behavioral health human resource needs across the state. The comprehensive, point-in-time count of all certified and licensed mental health professionals in Kentucky accomplished for the Commission is now available for comparison against national rates.

Representatives of Kentucky participated in a regional Provider Summit in November, 2000 to increase the availability of behavioral health professionals for states that serve the Appalachian region. The purpose of the Summit was to promote study by states of behavioral health care provider needs and to develop strategies to improve the availability of services and providers. The Health Resources and Services Administration and Substance Abuse and Mental Health Services Administration jointly sponsored the Summit, and are making on-going technical assistance available to work groups established by participating states. Meetings continue between the Department, Regional MH/MR Boards, Office of Inspector General and state higher education to promote the need for additional trained personnel.

While these initiatives are still in progress, comprehensive, accurate and valuable data are being collected that will assist Kentucky in making national comparisons and in developing meaningful plans to address human resource issues in Kentucky.

- **State Objective A-5-1:** Assist regions with developing evidenced based treatment protocols for specific mental health disorders in adults.

**Component 2: Cultural Competency**

There is an identified need to promote greater public awareness and recognition as to the importance of ensuring that behavioral health services are provided in a culturally competent fashion. The pertains not only to sensitivity in the areas of age, gender, race, ethnicity, religion, color, national origin, disability, and sexual orientation, but also relates to work experience, personality, geographic origin and ability and skill levels.

Due to the racial composition of Kentucky's population (91% Caucasian), there is a widely held perception that the state's population is essentially homogenous, thus making cultural competency a matter of little importance. On the contrary, Kentucky's population is quite diverse in its makeup. The largest variance within this population pertains to regional differences. The western portion of the state is largely agrarian, the Louisville and Lexington areas are urban, and the eastern portion of the state has a deep-rooted Appalachian culture. In addition, a large portion of Kentucky's African American community resides in western Louisville and near the two major military bases located in this state. Another relevant factor is the growing Hispanic segment of the populace.

- Advocate for the importance of recognizing and promoting the need to have as culturally competent a behavioral health work force as possible.
- The Department should continue to take a lead role in arranging for and providing ongoing training concerning its cultural competency curriculum.

- **State Objective A-5-2:** Continue to provide and promote at least two cultural competency "Training of Trainers" sessions each year.
- **State Objective A-5-3:** Ensure that all Department sponsored cultural competency training activities are responsive to the needs of the facilities and Regional MH/MR Boards and reflect best practice approaches in this field.

**Component 3: Training Initiatives**

A number of challenges confront the Department and Regional Boards in our effort to develop a well-trained workforce. These challenges include:

- With constant pressures to produce "billable hours", most clinicians have very little time to devote to training, especially training that is conducted out of the office;
- The cost of sending staff to training is a deterrent to most agencies with limited budgets;
- Training in evidence-based practices is difficult to sustain as it involves a comprehensive set of skills that need to be learned and practiced over time; and
- High turnover among direct service workers forces agencies to focus on basic training topics that all staff must have.

The Department's main strategy has been to sponsor a number of free or inexpensive statewide and focused regional training events through which Regional MH/MR Board staff can earn Continuing Education Units (CEUs) and obtain and maintain necessary certifications or licensures. Other strategies that are being examined include:

- Providing training through the Kentucky Virtual University or other internet based learning environments;

- Coordinating the scheduling of Departmental training and technical assistance events so that Regional Board staff do not have to travel as far or as frequently;
- Posting Department sponsored training events on the web; and
- Providing on-line registration for all training events.

❖ **State Objective A-5-4:** Develop a Community Support Program (CSP) training plan that identifies core topics and potential presenters, for delivery during quarterly CSP meetings, the Mental Health Institute, the Case Management Conference, and other scheduled CSP training events.

**Component 4: Financial Resources**
The obvious challenge for the Department is to maintain existing programs while Kentucky, along with most other states, face a growing crisis in state revenues. Other challenges include:
- Maintaining a focus on serving those most in need while allowing greater fiscal flexibility at the regional level;
- Expecting the same level of outcomes form programs that have not had an increase in funding in a decade; and
- Maintaining safety net services (e.g. crisis services) at the Regional level.

Strategies used by the Department include:
- Moving toward performance based contracting (allowing greater flexibility while holding Regional Boards more accountable for outcomes);
- Moving the focus to developing effective systems of care for adults with severe mental illnesses from developing specific program interventions; and
- Developing focused biennium budget requests that are based on a strong needs assessment, in concert with the HB 843 Commission.

❖ **State Objective A-5-5:** Develop a biennium budget request by August 30, 2005 that reflects the priorities established by the Mental Health Services Planning Council and the HB 843 Commission and that provides significant new funding for the "safety net" services at the regional level.

**Comments from the Mental Health Planning Council meeting on August 19, 2005:**

**A-5-1:** Comment: Are these EBPs about specific diagnoses?
*Response: Yes, somewhat and then there are overall ones as well (e.g., recovery model)*

**A-5-2:** Comment: How do we measure this (cultural competence)?
*Response: We have a staff person assigned to oversee all Division activities and have studied models from other states.*
Comment: Consumers should have access to cultural competency trainings offered by the Department.
*Response: Consumer organizations will definitely be added to the mailing list to receive notice of trainings.*

**A-5-3**: Comment: How about consumer training? The Leadership Academy is great but need more opportunities to plug people once trained.
*Response: We primarily rely on the advocacy organizations right now but if we can get a Peer Support Coordinator in every region, that person will know what opportunities are available. That's why we are working so closely with Medicaid.*
Comment: How do consumers get scholarships to MHI?
*Response: The Dept. will send letters to a number of the Regional MH/MR Boards, advocacy organizations and partner agencies to offer scholarships to staff and consumers/family members. We have 100 scholarships to offer from our Dept. and there may possibly be other organizations out there that will assist folks with attending.*

Comment: What about the individuals out there that are not part of any organization?
*Response: I do not think we will have additional scholarships this year but I can forward ideas you have on how to distribute scholarships for next year.*
Comment: Does our plan address adult literacy?
*Response: Yes, it is required in Criterion 1. TR programs encourage educational services. No payer source for educational activities in our arena.*
Comment: Can we focus on that?
*Response: I am not sure what we would do.*
Comment: Who's our education representative on the Council?
*Response: The voting representative from Education was not able to be here today. Perhaps we could seek her consultation on this matter at a future date.*

**A-5-4:** Comment: Can block grant funds pay for consumer run services (TR)?
*Response: There is nothing that precludes this but it is not happening in Kentucky to my knowledge.*
Comment: Can you see it happening with use of the recovery model? I wish Kentucky would look at what some other states have done.
*Response: Yes, over time.*